CHAPTER 25

PATIENT ADMINISTRATION DEPARTMENT

STANDARD OPERATING PROCEDURES

500 BED FLEET HOSPITAL

TABLE OF CONTENTS

500 BED FLEET HHOSPITAL

STANDARD OPERATING PROCEDURE

PATIENT ADMINISTRATION DEPARTMENT

A. **MISSION**: Develops and coordinates all procedures for the admission and disposition of patients and for the processing of medical records, reports and statistics pertaining to treatment.

B. **FUNCTIONS**:

1. Manage the Patient Administration Department.

2. Collect and record basic patient demographic data.

3. Prepare appropriate admissions records.

4. Track admissions, transfers, and discharges for all patients.

5. Administer local patient transportation.

6. Provide administrative support and interface with the medical evacuation system.

7. Prepare orders to transfer patients back to duty or to another treatment facility.

8. Provide for custody and disposition of personal effects and valuables.

9. Maintain personnel records and patient diary.

10. Coordinate Decedent Affairs.

11. Manage the flow of inpatient records.

12. Provide members on triage teams to record clinical assessments, and to record and monitor flow of patients throughout the hospital.

C. **PHYSICAL DESCRIPTION**:

1. Head, Patient Administration Department.

(a) Location within complex:

(b) Sheltering.

Type: Temper Tent.

Quantity: One half section, shared.

(c) Material.

IOL: ADOB-F, ADOP, ADOU,

2. Registrar Division.

(a) Location within complex:

(b) Sheltering.

Type: Temper Tent.

Quantity One half section, shared.

(c) Material.

IOL: ADOB-F, ADOP, ADOU.

3. Patient Personnel Division.

(a) Location within complex:

(b) Sheltering.

Type: Temper Tent.

Quantity: One half section, shared.

(c) Material.

IOL: ADOB-F, ADOP, ADOU

4. Medical Records Division.

(a) Location within complex:

(b) Sheltering.

Type: Temper Tent.

Quantity: One half section, shared.

(c) Material.

IOL: ADOB-F, ADOP, ADOU

D. **SPECIAL CONSIDERATIONS:**

During mass casualty and peak load periods, Casualty Receiving is assigned the most important manning priority. There are two watch stations in this area. The first and most important is the Control Point adjacent to the entrance where all initial documentation begins for each patient. The second is adjacent to the exit where forms are checked and subsequent routing is logged.

E. **WORKLOAD:**

1. 80 steady state (routine) admissions/day.

   (a) 54 surgical cases routed directly to OR Preparation and Holding.

   (b) 23 medical cases routed to Acute Care Wards.

   (c) 3 medical cases routed to ICUs.

2. 120 peak period admissions/day.

   (a) 80 surgical cases routed directly to OR Preparation and Holding.

   (b) 35 medical cases routed directly to Acute Care Wards.

   (c) 5 medical cases routed directly to ICUs.

3. Average length of patient stay is 4 days.

4. 12 patients discharged to duty/average day.

5. 70 patients evacuated to the rear/average day.

6. 2-4 patients die/average day.

F. **ORGANIZATION:**

1. Responsibility. The Head, Patient Administration Department, who reports to the Director of Administrative Services, is assigned overall management responsibility. The department is divided into 3 Divisions.

(a) Registrar Division.

(b) Patient Personnel Division.

(c) Medical Records Division.

2. Organizational chart.

Patient Administration

C.O.

X.O.

Dir. Admin Service

Head Patient Administration

3. Staffing.

(a) Criteria.

(1) Two 12 hour watches.

(2) Peak workload assumed to occur on AM watch.

(3) All Patient Administration personnel will be cross-trained in patient admission procedures.

(4) Patient Personnel Division Supervisor should be a Hospital Corpsman with personnel training/experience so that he may be employed in clinical areas as needed.

(b) Staffing Pattern.

	AM Watch	Night Watch	Total Assigned
Head, Patient Admin	1 (04)	-	1
Patient Affairs Officer	1 (01)		1
Patient Affairs Supervisor	1 (E-8)	-	1
Patient Affairs Clerk	1 (E-4)	1 (E-4)	2
Medical Records Supervisor	1 (E-7)	-	1
Med Records Supv Asst	1 (E-3)		1
Medical Records Clerk	3 (E-4)	2 (E-4)	5
Medical Records Clerk	2 (E-3)	1 (E-3)	3
Registrar	1 (E-7)	-	1
Admissions Clerk	3 (E-4)	2 (E-4)	5

Patient Effects Clerk	1 (E-3)	1 (E-3)	1
Medical Evacuation Coordinator	1 (E-6)	-	1
Medical Evacuations Coord. Asst	-	1 (E-4)	1
Decedent Affairs Super.	1 (E-7)	-	1
Decedent Affairs Clerk	1 (E-5)	1(E-4)	2

4. Assignments by billet sequence code: See TAB A, page 13.

5. Watch bill: See TAB B, page 15.

6. Special watches: N/A

G. <u>TASKS</u>:

	TASK		METHOD
1.	ADMITTING PATIENTS	1.1	When a patient is ordered admitted, the Admission Watch will follow the following procedures:
		1.1.A	Obtain the admission packet bearing the lowest available register number. For detailed information regarding these packages, see TAB C-1.
		1.1.B	Verify that the admission packet selected corresponds with the near available register number in the A&D Log. For detailed information regarding this Log, see TAB C-2.
		1.1.C	Complete blocks 1-3, 4, 6, 7, 12, 17, 19, 21, 27 of NAVMED 6300/5 (A&D Form) before patient leaves Casualty Receiving. For detailed information regarding this form, see TAB C-3.

1.1.D Enter the appropriate information on the identification band insert and secure the band to the patient's wrist.

1.1.E Separate the copies of the Admission and Disposition Form. Distribute as follows:

- Long copy and short white copy - Removed and retained for Patient Administration.

- Green Copy - Removed and stapled to inpatient record jacket.

- All other copies left as found for future use.

1.1.F Fill out the baggage tag(s). Secure tags to appropriate belongings and attach receipt portion to records jacket.

For detailed information regarding this tag and a completed sample, see TABs C-4 and F-2.

1.1.G Notify the Registrar Watch of the admission, providing the basic information contained on the Admission and Disposition Form.

1.1.H Inpatient record jacket will remain with patient to include evacuation or

discharge. Unused packet items stay with jacket.

2. COLLECTING PATIENT VALUABLES

2.1 For the purpose of these procedures, valuables are considered to include cash, other negotiables, jewelry, and watches.

2.2 The Admissions Watch will advise each patient during the admitting process that valuables may be deposited for safekeeping. Should the patient wish to make such a deposit, the watchstander will:

2.2.A Obtain the Property Storage Bag, NAVMED 6010/8, with attached Deposit Record, from the patient's Admission Packet, and enter the appropriate identifying information. For detailed information regarding this bag and record, see TAB C-5

2.2.B Inventory the valuables to be deposited and complete the inventory section of the Deposit Record Form. Sign the Deposit Record Form as an interim custodian of the deposited valuables.

2.2.C Obtain the patient's signature acknowledging the deposit.

2.2.D Attach the patient's

receipt
copy of the Deposit Form
to
Treatment Record (see TABs
C-1 and C-5).

2.2.E Deliver the valuables to
the
Patient Personnel
Watchstander and obtain
the
latters receipt for same.

2.3 If an admitted patient is
unconscious, scheduled for
immediate surgery, or
otherwise incapable of
protecting his own
valuables,
the Admissions Watch will
automatically search for
and
confiscate any valuables.
He
will do so in the presence
of
a witness and obtain that
witness' signature
attesting
to the deposit.

2.4 One of the members
conducting
the inventory must be an
officer who is not
collaterally assigned as
valuables custodian.

2.5 Maintain an alphabetical
file
of copies of Deposit
Record
Form in patient
administration spaces next
to
secure storage area. File
maintained by patient
effects
clerk or authorized
Patient
Administration

Watchstander. (See TAB C-5)

3. PREPARING ADMISSIONS AND DISPOSITION REPORT	3.1	The Registrar Watchstander will prepare an Admissions and Disposition Report as of 2400 each day. For detailed information regarding this report and a completed sample, see TABs C-6 and F-19. Specifically, the watchstander will:
	3.1.A	Close the A&D Log in accordance with TAB C-2.
	3.1.B	Transpose required data from A&D Log to report form.
	3.1.C	Obtain admission information for Admission and Disposition\Form (6300/5).
	3.1.D	Obtain signature of Senior Department Watchstander.
	3.1.E	Prepare 14 copies.
	3.1.F	Retain original in chronological file within Patient Administration Department.
	3.1.G	Distribute copies to: Director of Administrative Services 4 ea, Department Heads 1 ea
4. INITIATE AND MAINTAIN INPATIENT RECORD JACKET	4.1	When a patient is admitted, open Inpatient Record Jacket as follows:
	4.1.A	Obtain a copy of Inpatient Record Jacket, NAVMED

6150/16.

4.1.B Attach green copy of A&D form.

4.1.C Secure forms to cover as directed in TAB C-1.

4.2 Record medical entries as directed in TAB C-1.

4.3 Review Inpatient Record Jacket and verify completeness and accuracy prior to patient discharge.

4.4 Attending physician must sign record.

4.5 Inpatient Record Jackets will accompany patients upon discharge or evacuation. Unused forms in admissions packet will remain with jacket.

5. PREPARE BED STATUS BOARD

5.1 This board, established at the start of operations, is critical in maintaining a perpetual, accurate status of all hospital beds (see TABs C-7 and F-19).

5.1.A When a patient arrives at OR Prep and Hold, Operating Rooms, ICU's, or other wards, an area representative will notify the Registrar Watchstander.

5.1.B The Registrar Watchstander will post these

notifications on the status board.

5.1.C The board will be updated as notifications are received demand will be summarized to indicate bed availability every 30 minutes.

6. EVACUATE PATIENTS

6.1 Upon receipt of evacuation request, Patient Administration Watch will:

6.1.A Complete appropriate areas of Patient Evacuation Tag DD Form 602 return to attending physician for signature, see TAB-C, Appendix 1, Section 4.

6.1.B Complete Patient Evacuation Worksheet DA Form 2496. (See TAB F-1)

6.2 Immediately prior to evacuation the Patient Administration Watch will:

6.2.A Brief patients on evacuation. (See TAB C-8)

6.2.B Check medical records for completeness. (See TAB C-8)

6.2.C Make checked baggage available for transport to staging area NLT 30 minutes prior to departure time. (See TAB C-8 Appendix 1 Section 4)

6.2.D Manifest patients, care for valuables prepare litters, and restrain patients if necessary. (See TAB C-8, Appendix 1 Section 4)

7. RECORD AND REPORT VERY SERIOUSLY ILL (VSI) AND SERIOUSLY ILL (SI) PATIENTS

7.1 The Registrar Watchstander will receive written notification via NAVMED 6320/5 when patient is classified/declassified VSI or SI. Upon receipt of such notification the watchstander will:

7.1.A Enter the appropriate transaction in the VSI/SI Log. For detailed information regarding this log.

7.1.B Prepare appropriate message notification in accordance with formats provided in TAB F-25.

7.1.C Collect any patient valuables, if requested by Ward Staff. Procedures are contained in TAB C-5.

8. COORDINATE DECEDENT AFFAIRS

8.1 Upon notification by nursing personnel that a death has occurred, the Decedent Affairs Watchstander of the Patient Personnel Division will:

8.1.A Obtain the Inpatient Record Jacket and Certificate of Death (see TAB C-9).

8.1.B Obtain inventoried valuables and personal effects and prepare DD Form 1076.

8.1.C Complete the Hospital Report of Death and actions required by it.

8.1.D Prepare required message notifications (TABs C-9 and F-25).

8.1.E Take appropriate actions to dispose of remains, valuables, and effects (TAB C-9).

9. DISCHARGE PATIENT TO DUTY

9.1 When a patient is determined to be fit for duty, the attending physician will:

9.1.A Chart discharge orders.

9.1.B Prepare a short-form narrative summary.

9.2 The ward staff will:

9.2.A Prepare the patient for discharge.

9.2.B Return any effects stored on the ward.

9.2.C Deliver the patient, records, and narrative summary to Patient Personnel Division.

9.3 The Patient Personnel Watch will:

9.3.A Notify the patient's unit of the pending discharge and request transportation and uniforms as appropriate.

9.3.B Return any centrally stored valuables and personal effects.

9.3.C Provide the patient with a copy of the narrative summary with instructions to deliver it to those who hold his health record.

9.3.D Insert a copy of the narrative summary in the Inpatient Treatment Record.

9.3.E Retain the record (Note 1).

9.3.F Make appropriate entries in the Admissions and Discharge Log.

NOTE 1: SECNAVINST 5212.5 directs that inpatient records be retained at the health care facility for 2 years and then retired to:

National Personnel Record Center
MPR
9700 Page Boulevard
St. Louis, MO 63132

Since the Fleet Hospital is not equipped for such retention, the holding period is waived and records will be retired as they accumulate to reasonable shipping quantities.

H. STANDARD OPERATING PROCEDURES: See TAB C, page 16

I. CLINICAL POLICIES/GUIDELINES: N/A

J. STANDARDS AND JOB DESCRIPTIONS: See TAB D, page 84

K. DOCUMENTATION:

1. References See TAB E, page 95
2. Forms See TAB F, page 97

TAB A

PERSONNEL ASSIGNED BY BILLET NUMBER

BSC	TITLE	DESIG/NEC	GRADE	WATCH
16029	HEAD, PATIENT ADMIN DEPT	2300/1800	0-3	AM SHIFT ONLY
16049	PATIENT AFFAIRS OFFICER	2300/1801S	0-1	2
16019	PATIENT AFFAIRS SUPERVISOR	0000/HM	E-8	2
16039	PATIENT AFFAIRS CLERK	0000/HM	E-4	1
16041	PATIENT AFFAIRS CLERK	0000/HM	E-4	2
16059	MEDICAL RECORDS SUPERVISOR	0000/HM	E-7	1
16079	MEDICAL RECORDS SUPV. ASST	0000/HM	E-6	2
16099	MEDICAL RECORDS CLERK	0000/HM	E-5	1
16101	MEDICAL RECORDS CLERK	0000/HM	E-5	2
16119	MEDICAL RECORDS CLERK	0000/HM	E-3	1
16121	MEDICAL RECORDS CLERK	0000/HM	E-3	2
16123	MEDICAL RECORDS CLERK	0000/HM	E-3	1
16139	REGISTRAR	0000/HM	E-7	1
16159	ADMISSIONS CLERK	0000/HM	E-4	1
16161	ADMISSIONS CLERK	0000/HM	E-4	2
16163	ADMISSIONS CLERK	0000/HM	E-4	1
16165	ADMISSIONS CLERK	0000/HM	E-4	2
16167	ADMISSIONS CLERK	0000/HM	E-4	1
16179	PATIENT EFFECTS CLERK	0000/HM	E-3	1
16181	PATIENT EFFECTS CLERK	0000/HM	E-3	2
16199	MEDICAL EVACUATION COORD	0000/HM	E-6	1

16219	MEDICAL EVACUATION CLERK	0000/HM	E-4	2
16239	DECEDENT AFFAIRS SUPERVISOR	0000/HM	E-7	1
16259	DECEDENT AFFAIRS CLERK	0000/HM	E-5	2
16261	DECEDENT AFFAIRS CLERK	0000/HM	E-5	1

TAB B

WATCHBILL FOR PATIENT ADMINISTRATION

Section 1

M T W T F S S M T W T F S S M T W T F S S M T W T F S S M T

A A A A A A*E P*P P P P P*E A*A A A A A*E P*P P P P P*E A*A

Section 2

E P P P P P P* E A*A A A A A* E P*P P P P P* E A*A A A A A* E P*

* = Dog watch.

TAB C

STANDARD OPERATING PROCEDURES

INDEX

TAB C-1

ADMISSION PACKET

A. PURPOSE: To provide a means to ensure that all forms and supplies required to admit a patient are immediately available to Admissions Watchstanders.

B. PROCESS: The following procedures are valid whether you use the manual system or an automated system. You will note that the automated system will produce some of the forms and reports that are required by this section. Become familiar with the capabilities of the automated system in order to avoid duplicate work.

C. DEFINITION: Pre-assembled, pre-numbered packets, prepared by the Registrar Division containing all the necessary forms and supplies to initially admit a patient to the fleet hospital. They are stored, in sufficient quantity to support an entire watch, in a container adjacent to the casualty receiving control desk.

D. EQUIPMENT, SUPPLIES AND FORMS REQUIRED:

1. Admission and Disposition Form, NAVMED 6300/5.
2. Patient identification wristband.
3. Inpatient treatment record cover sheet.
4. Patient medical card, DD 1380.
5. Patient's property storage bag, NAVMED 6010/8.
6. Baggage tags (4), DD Form 600.
7. SF 600 Chronological Record of Medical Care.
8. All commonly used laboratory requests.
    (a) SF 546 Chemistry I.
    (b) SF 549 Hematology.
    (c) SF 500 Urinalysis.

(d) SF 557 Miscellaneous.

9. Radiology request Form SF 519A.

10 Record of personal effects, DD Form 1076.

11. Inpatient Record Jacket, (NAVMED 6150/16), with forms attached.

(a) Left Side - NAVMED 6300/5.

(b) Right Side.

(1) SF 539 Abbreviated Clinical Record.

(2) SF 508 Doctors Orders.

(3) SF 507 Continuation Sheets (5 ea).

(4) SF 509 Doctors Progress Note.

(5) SF 510 Nurses Notes.

(6) SF 511 TPR Chart.

(7) SF 518 Blood Transfusion Request.

(8) SF 519 X-ray (Radiographic Backing Sheet).

E. CRITERIA:

1. A minimum of 50 packets will be available in Casualty Receiving at the beginning of each watch.

2. Packet numbers will be serial and correspond to the next sequential block of numbers available in the Admissions and Dispositions Log. For more detailed information regarding this log, see TAB C-2.

F. STEPS:

1. Assemble all required forms.

2. Enter the first available register number from Admissions and Disposition Log in appropriate space on each form and seal.

3. Assemble Inpatient Record Jacket (NAVMED 6150/16) as

follows:

(a) Enter register number.

(b) Enter UIC.

(c) Inside on left side attach.

(1) NAVMED 6300/5.

(d) Inside right side attach.

(1) SF 539.

(2) SF 508.

(3) SF 507.

(4) SF 509.

(5) SF 510.

(6) SF 511.

(7) SF 518.

(8) SF 519A.

4. Attach pre-numbered sealed Admissions Packet to the same numbered Inpatient Record Jacket.

5. Assemble the required number of packets to meet the above criteria, ensuring that each form in a packet bears the same register number and that each packet is numbered sequentially after the first.

G. RESPONSIBILITY:

Registrar watchstander.

TAB C-2

ADMISSION AND DISPOSITION LOG

A. PURPOSE: To provide a sequential, chronological, legal record of patients admitted to and discharged from the Fleet Hospital.

B. DEFINITION: A hard-bound log (record book) containing the minimum essential information required to identify patients admitted and to determine disposition of patients discharged.

C. EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:

Standard record book.

D. CRITERIA:

1. Log must be updated frequently to ensure that a central record of all admissions is readily available.

2. At a minimum, it will be updated before the Registrar Watchstander is relieved.

E. STEPS:

1. The front cover must be marked with the Fleet Hospital Unit Identification Code (UIC), the title "A&D Log," and the date of initial entry.

2. Each set of facing pages will be divided into vertical columns. Columns will be labelled "Date," "Register Number," "Patient name," "Patient Rank/Rate," "Patient SSN," "Patient Unit," "Diagnosis/impression," "Date Discharged," and "Disposition".

3. Register numbers correspond with numbers assigned to Admissions Packets and are entered at the time that the packet is assembled. For detailed information regarding Admissions Packets, see TAB E-1.

4. Entries will mirror data contained on the corresponding Admissions and Disposition Form.

5. The log will be closed at 2400 each day by drawing a double horizontal line beneath the last entry.

6. When the log is full, it will be closed by marking the date of the last entry on the front cover.

7. All logs will be maintained in the Registrar Division.

F. RESPONSIBILITY:

Registrar Watch.

TAB C-3

ADMISSION AND DISPOSITIONS FORM NAVMED 6300/5

A. PURPOSE: To record detailed data on all patients admitted.

B. DEFINITION: The automated system will produce an Inpatient Treatment Record Cover Sheet (ITRCS) that may be used in place of the SF 6300/5. The ITRCS contains all of the data elements of the SF 6300/5 and should be completed in full prior to the patient being discharged.

C. EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:

1. Zenith 248 PC.

2. Dumb terminal/keyboard for Casualty Receiving.

3. Computer paper.

4. NAVMED form 6300/5.

D. CRITERIA: (Automated system)

1. Complete as much as possible in Casualty Receiving on the QUICK ADMIT screen before the patient is moved to the next treatment location. The Admissions Clerk will obtain complete information on each patient when time permits.

A PATIENT IS NEVER TO BE DELAYED FOR ADMINISTRATIVE REASONS.

2. Ensure copy of QUICK ADMIT screen is placed in the patient's chart.

E. STEPS:

1. Complete as much as possible in Casualty Receiving on the QUICK ADMIT screen before the patient is moved to the next treatment location. The Admissions Clerk will obtain complete information on each patient when time permits.

2. All data elements must be completed prior to the discharge of any patient. As always, DO NOT DELAY MEDICAL CARE

BECAUSE OF ADMINISTRATIVE PROCESSING.

3. Copy of the ITRCS must become part of the patient's medical record.

4. When using the manual mode, be sure to complete NAVMED form 6300/5 in its entirety. Instructions for the completion of this form may be found in NAVMEDCOMINST 6300.3 series.

(a) Blocks 1, 2, 3, 4, 6, 7, 12, 17, 19, 21, and 27 <u>should</u> be completed in Casualty Receiving.

(b) All other data elements are to be collected prior to discharge.

5. Parts will be distributed as follows:

(a) Long original, long copy and short white copy - removed and retained for Patient Administration.

(b) Green copy - removed and stapled to Inpatient Record Jacket.

(c) All other copies - left as found for future use.

6. Blocks will be completed in accordance with NAVMEDCOMINST 6300.3 Series. Abbreviated instructions for most commonly used entries follows:

TAB C-3.1

PREPARATION OF NAVMED 6300/5 (REV. 5-79), INPATIENT ADMISSION/DISPOSITION RECORD

ADMISSION PORTION

1. Inpatient Admissions. Upon admission, blocks 1 through 36 (excluding blocks 31 and 32) of the NAVMED 6300/5 (Rev. 5-79) shall be completed in accordance with the below instructions. Immediately following each block title, a notation appears indicating the categories of patients for which the data element must be recorded or coded.

BLOCK 1. PATIENT'S NAME (required for all inpatients). Enter inpatient's name--Last, First, Middle--as illustrated in the following examples.

PATIENT'S NAME (Last, First, Middle)
FRANKLIN, BENJAMIN JAMES

BLOCK 2. TIME ADMITTED (required for all inpatients). Enter time inpatient was admitted, using a 24-hour clock time.

BLOCK 3. ADMISSION DATE (required for all inpatients).
Enter day (numeric date), month (numeric symbols authorized: 01, 02, 03, 04, 05, 06,
07, 08, 09 for January, February, March, April, May, June, July, August, September, and
10, 11, 12 for October, November, December),
calendar year (last two digits).

ADMISSION DATE Example of patient admitted.
DAY MONTH YEAR on 10 January 1980:
100180.

BLOCK 4. REPORTING MEDICAL TREATMENT FACILITY (UIC) (required for all inpatients). Enter the five-digit reporting facility code: 68681.

REPORTING MEDICAL TREATMENT FACILITY

FACILITY (UIC) - 68681

BLOCK 5. LOCATION CODE

NOTE: This item is to be recorded by non-fixed naval medical inpatient treatment facilities only (i.e., ships, mobile units, etc.). Refer to coding instructions in section XII.

BLOCK 6. REGISTER NO. (Required for all inpatients.)
This block should have been completed when the form was inserted in the Admissions Packet.

If it is blank, enter the number of the Packet from which it was removed.

REGISTER NO. Example of patient assigned. 0000181 - register number: 181

BLOCK 7. DUTY STATION (required for active duty, U.S. Navy and Marine Corps inpatients). Enter the official name and address of the duty station to which the Navy or Marine Corps inpatient was permanently attached at the time of original admission to the sicklist for this current continuous period of hospitalization.
Record for active duty, U.S. Navy and Marine Corps inpatients only. Refer to instructions in section XII.

DUTY STATION, ACDU NAVY & MARINE CORPS ONLY. 2nd Battalion 2nd Mardiv 6th Marines FMFLANT

BLOCK 8. FAMILY MEMBER PREFIX (required for all inpatients). Family Member Prefix (Patient Status). Enter the appropriate number in the box preceding the SSN block. Use the following code:

PATIENT STATUS

FAMILY MEMBER PREFIX RELATIONSHIP TO SPONSOR

20 - Sponsor (active duty, reserve, and retired uniformed services personnel: Army, Navy, Air Force, Marine Corps, Coast Guard, Public Health Service, and National Oceanic and Atmospheric Administration).

00 - All other authorized personnel (Foreign nationals, including foreign military; civilian humanitarians; etc).

8 - FAMILY MEMBER PREFIX
Example for sponsor: 20

BLOCK 9. SOCIAL SECURITY NUMBER (required for all U.S. citizens). Enter patient's SSN in the block provided. If SSN is unavailable, enter 999-99-0001 for the first admission without an SSN, 999-99-0002 for the second, and so on.

SOCIAL SECURITY NO. - Example of sponsor's Social Security Number: 641287521

BLOCK 10. SEX CODE (required for all inpatients). Enter appropriate one-letter sex code in block provided using the appropriate code below.

DESCRIPTION CODE	SEX CODE
Male	M
Female	F

SEX CODE
Example of sex code for male patient: M

BLOCK 11. RACE (required for all inpatients).

Enter the abbreviation for race of the patient as indicated from the following:

RACE ABBREVIATION CODE

DESCRIPTION	ABBREVIATION	CODE

Caucasian	CAUC	C
Negroid	NEGRO	N
Mongolian	MONG	G
Indian	IND	I
Malayan	MAL	M

RACE. Example of patient of Caucasian race: C

BLOCK 12. RELIGION (optional). Recording of religious denomination is at the discretion of the local command. If used, suggested DOD standard descriptions and abbreviations are provided.

RELIGIOUS DENOMINATION

DESCRIPTION	ABBREVIATION
No religious preference	NO-REL-PREF
Adventist, Seventh Day	ADV-SEV-DAY
Assemblies of God	ASBY-GOD
Baptist-American Baptist Convention	AMER-BAPT
Baptist-Other groups	BAPT-OTHER
Brethren	BRETH
Buddhism	BUD
Christian Science	CHR-SCI
Church of Christ	CH-CHR
Church of God	CH-GOD
Disciples of Christ	DIS-CHR
Episcopal	EPISC
Friends	FRIENDS
Jehovah's Witnesses	JEH-WIT

RELIGIOUS DENOMINATION --cont'd

DESCRIPTION	ABBREVIATION
Jewish	JEWISH
Latter Day Saints	LAT-DAY-ST
Lutheran (includes Missouri Synod)	LUTH
Methodist (includes Evangelical United Brethren)	METH
Evangelical Covenant	EVANG-COV
Muslim	MUSLIM
Nazarene	NAZ
Orthodox	ORTH
Pentecostal	PENT
Presbyterian	PRESBY
Reformed	REFMD

Roman Catholic	ROMAN-CATH
Salvation Army	SAL-ARMY
Unitarian Universalist	UNITN-UNIV
United Church of Christ	U-CH-CHR
Protestant Other Churches	PROT-OTHER
Protestant no denominational Preference	PROT-NO-DENOM
Other religions	OTHER-REL
Unknown	UNK

BLOCK 13. HOME ADDRESS/DUTY STATION

DUTY STATION (required for active duty U.S. Army and Air Force patients only). Record duty station and ZIP code in block provided.

BLOCK 14. MARITAL STATUS (optional). Enter marital status using abbreviations below:

MARITAL STATUS

DESCRIPTION	ABBREVIATION
Annulled	ANU
Divorced	DIV
Interlocutory	INT
Legally Separated	LEG
Married	MAR
Single	SIN
Widowed	WID
Unknown	UNK

BLOCK 15. BIRTH DATE (required for all inpatients).

Enter day (numeric date), month (numeric symbols authorized), calendar year of birth (last two digits).

BIRTH DATE - Example of patients's birth date. DAY MONTH YEAR: 180350

BLOCK 16. LENGTH OF SERVICE (required for active duty, U.S. uniformed services inpatients only).

Enter length of service in years and months. All active duty service in all U.S. uniformed

services shall be counted.

LENGTH OF SERVICE - Example of patients's length of service.
YRS MOS: 0609

BLOCK 17. PAY GRADE CODE (required for active duty inpatients). Enter the pay grade code of patients as applicable from the following code structure. Pay grade codes for commissioned officers are numeric only. All other codes are alphabetic and numeric.

PAY GRADE

FLAG OR GENERAL COMMISSIONED OFFICERS

GRADE	CODE
0-11	11
0-10	10
0-9	09
0-8	08
0-7	07

COMMISSIONED OFFICERS

GRADE	CODE
0-6	06
0-5	05
0-4	04
0-3/0-3E	03
0-2/0-2E	02
0-1/0-1E	01

WARRANT OFFICERS

W-4	W4
W-3	W3
W-2	W2
W-1	W1

ENLISTED

GRADE	CODE
E-9	E9
E-8	E8
E-7	E7
E-6	E6
E-5	E5

E-4	E4
E-3	E3
E-2	E2
E-1	E1

PAY GRADE CODE. Example of enlisted patient, in pay grade 4: E-4

BLOCK 18. DESIG/MOS/NEC (DESIGNATOR/MILITARY OCCUPATION SPECIALTY/NAVY ENLISTED CLASSIFICATION) (required for active duty U.S. Navy and Marine Corps inpatients.

U.S. Navy Officer/Warrant Officer. Enter the first two digits of the designator in block provided.

DESIG/MOS/NEC. Example of line officer patient, designator 1100: 11

U.S. Navy Enlisted. Enter the first two authorized characters of the rating abbreviation in block provided.

DESIG/MOS/NEC. Example of aviation structural mechanic, AM hydraulics, patient

U.S. Marine Corps Officer and Enlisted. Enter the first two digits of the military occupation specialty (MOS) number in block provided.

DESIG/MOS/NEC. Infantry Officer, 0302: 03

DESIG/MOS/NEC. Enlisted card punch operator, 4013: 40

BLOCK 19. RECORDS REC.(RECEIVED) (optional). If used, enter date records received.

RECORDS

DESCRIPTION	ABBREVIATION
Health Record	HR
Dental Record	DR

Service Record	SR
Pay Record	PR
Orders	ORD
Personal Effect	PE

BLOCK 21. PATIENT CATEGORY (required for all inpatients).

(a) Enter patient category abbreviation as identified below.

MEMBERS OF U.S. UNIFORMED SERVICES IN ACTIVE DUTY

DESCRIPTION	ABBREVIATION	CODE
Active Duty U.S. Navy	ACDU-N	N11
Active Duty U.S. Marine Corps	ACDU-MC	M11
Active Duty U.S. Army	ACDU-A	A11
Active Duty U.S. Air Force	ACDU-AF	F11
Active Duty U.S. Coast Guard	ACDU-CG	P11
Active Duty U.S. Public Health Service	ACDU-PHS	W11
Active Duty U.S. National Oceanic and Atmospheric Administration	ACDU-NOAA	011

MEMBERS AND DEPENDENTS OF MEMBERS OF FOREIGN MILITARY/SECRETARY OF NAVY DESIGNEE

DESCRIPTION	ABBREVIATION	CODE
NATO Active Duty	NATO-AD	S51
Non-NATO Active Duty	NON-NATO-AD	S53
SECNAV Designee	FORMILSECNAVDESIG	S58

EMPLOYEES AND DEPENDENTS OF EMPLOYEES OF FEDERAL AGENCIES

DESCRIPTION	ABBREVIATION	CODE
U.S. Civilian Employee-NEC	CIVEMP-NEC	H61
OTHER ELIGIBLES NOT ELSEWHERE CLASSIFIED	(NEC)	

DESCRIPTION	ABBREVIATION	CODE
Enemy Prisoner of War	EPW	Q81
Merchant Marine-Military Sealift Command	MERMAR-MSC	X82
American Red Cross	ARC	X86
Civilian Humanitarian-Non-Indigent	CIVHUM-NI	X87
Civilian Humanitarian-Indigent	CIVHUM-I	X88
All Other-NEC	AO-NEC	X89

(b) Enter a three-digit patient category code in the block provided using a code found above.

PATIENT CATEGORY CODE. Example of patient category. ACDU-N CODE active duty, U.S. Navy: N11

BLOCK 22. TYPE OF ADMISSION (required for all inpatients).

(a) Enter as an admission type abbreviation, one of the following:

(1) Inpatients

a Direct (D). The admission should be recorded as direct if the reporting medical treatment facility is the first medical treatment facility to place the patient under treatment or observation for the current episode of illness or injury. Recurrence or sequela of previously treated conditions shall be considered as a new and separate episode of illness.

b From Transfer, Military Facility (FT(M). The admission shall be considered to be from transfer, military facility, when the inpatient

is received transferred in an inpatient status) from another DOD medical treatment facility.

22. TYPE OF ADMISSION CODE. Example of patient transferred from military facility: (FT(M)).

c From Transfer, Other Medical Facility (FT(O)). The admission shall be considered to be from transfer, other medical facility, when the inpatient is received (transferred in an inpatient status) from a U.S. or foreign civilian or government medical treatment facility provided that the government facility is neither U.S. Army, Navy, or Air Force.

ADMISSION TYPE CODE

TYPE OF ADMISSION	ABBREVIATION	CODE
Direct	D	00
From transfer (Army, Air Force, Other Navy medical treatment facility)	FT(M)	10
From transfer (other medical facilities)	FT(O)	11

(b) Enter the two-digit admission type code in the block provided using a code listed above.

22. TYPE OF ADMISSION CODE. Example of patient admitted from FT(M) transfer from an Army medical treatment facility: 10.

BLOCK 23. MIL.TH.OP. (MILITARY THEATER OF OPERATIONS). Enter NAVMEDCOM designated code.

BLOCK 24. NEXT OF KIN/SPONSOR (optional). Enter data

identifying next of kin.

(a) Enter the abbreviation for the service to which the patient is assigned for professional management regardless of diagnosis.

CLINIC/SERVICE

CLINIC/SERVICE	ABBREVIATION	CODE
1. MEDICAL CARE		
INTERNAL MEDICINE	INTRNL-MED	AAA
2. SURGICAL CARE		
GENERAL SURGERY	GEN-SURG	ABA
CARDIOVASCULAR AND THORACIC SURGERY	CARIOVASC-THORCIC-SURG	ABB
INTENSIVE CARE (SURGICAL)	IC-SURG	ABC
NEUROSURGERY	NEUROSURG	ABD
OPHTHALMOLOGY	OPHTHLMLGY	ABE
ORAL SURGERY	ORAL-SURG	ABF
OTORHINOLARYNGOLOGY	ENT	ABG
UROLOGY	UROL	ABK
3. OBSTETRICAL AND GYNECOLOGICAL CARE		
GYNECOLOGY	GYN	ACA
4. ORTHOPEDIC CARE		
ORTHOPEDICS	ORTHO	AEA
PODIATRY	PODIAT	AEB
5. PSYCHIATRIC CARE		
PSYCHIATRY	PSYCH	AFA

(b) Enter the three-letter clinic/service code in block provided using a code found above. The fourth position is for local command use only.

BLOCK 25. CLINIC/SERVICE CODE. Example of patient admitted to orthopedic care: ORTHO - AEA

BLOCK 26. NOTIFY IN CARE OF EMERGENCY IF OTHER THAN

NEXT OF KIN (optional).

BLOCK 27. ADMISSION DIAGNOSIS (required for all inpatients). Enter the primary admitting diagnosis (established or provisional) in medical terminology consistent with current acceptable professional usage. The body part or anatomical site shall be stated for the diagnosis where it is relevant. Consider as the primary diagnosis the immediate condition which necessitated admission. If two or more related or unrelated conditions are present upon admission, the medical or dental officer shall designate as the primary diagnosis the most serious condition for which the patient was admitted.

ADMISSION DIAGNOSIS. Example of admitting diagnosis: PNEUMONIA

BLOCK 28. MEDICAL TREATMENT FACILITY TRANSFERRED FROM (required for all inpatients received from transfer). Record name and location of medical treatment facility transferred from.

MEDICAL TREATMENT FACILITY-TRANSFERRED FROM. Example of patient transferred 2nd Medical Battalion Company B transferred 2nd Mardiv: FMFLANT

BLOCK 29. ORIG. ADM. DATE (ORIGINAL ADMISSION DATE) (required for all inpatients). Enter day (numeric date), month (numeric symbols authorized), and calendar year (last two digits) in which patient was first admitted for the current period of uninterrupted hospitalization.

ORIGINAL ADMISSION DATE. Example of patient first admitted 2 January 1980.
DAY MONTH YEAR: 020180

BLOCK 30. CIRCUMSTANCE OF ACCIDENT, VIOLENCE, POISONING (CAUSE OF INJURY) (required for all inpatients when applicable).

For a current accident, violence, or poisoning, enter the following.

(a) For all active duty, U.S. uniformed services patients, indicate yes or no by placing a "Y" or "N" in on duty line to identify the patient's duty status at the time of occurrence (of the accident, violence, or poisoning).

(b) For all patients, include a concise statement of circumstances of occurrence. Brief answers to the following questions will provide an appropriate statement:

what, when, where, and how did it happen and to what degree and in what way did the individual participate?

30. CIRCUMSTANCES OF ACCIDENT, VIOLENCE, POISONING

(a) ACTIVE DUTY U.S. UNIFORMED SERVICES ON DUTY (INDICATE Y OR N)

(b) RECORD BRIEFLY - WHAT, WHEN, WHERE, HOW

OF 16 JAN 1980 CAUSE CODE PATIENT GSW RT Arm. Example of circumstance of accident: Hostile Fire

BLOCK 31. DISPOSITION DATE (required for all inpatients). Enter day (numeric date),

month
(numeric symbols authorized) and calendar year (last two digits) of patient's disposition from the treatment facility.

DISPOSITION DATE. Example of patient discharged, DAY MONTH YEAR. 12 December 1980: 121280

BLOCK 32. DISPOSITION TO (required for all inpatients).
Record in accordance with disposition types
listed in block 49.

DISPOSITION TO. Example of discharged to Duty: RTD

BLOCK 33. PATIENT'S NAME (required for all inpatients).
Enter inpatient's name (Last, First, Middle)
as illustrated.

PATIENT'S NAME (LAST, FIRST, MIDDLE)
FRANKLIN, BENJAMIN JAMES

BLOCK 34. GRADE/RATE (optional).

BLOCK 35. WARD (optional).

BLOCK 36. REPORTING MEDICAL TREATMENT FACILITY (optional).

TAB C-4

STORAGE OF PATIENT'S CLOTHING AND PERSONAL EFFECTS

A. **PURPOSE**: To provide local control of personal effects \ retained in secure storage spaces.

B. **DEFINITION**: A two-part perforated tag with attachment strings.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED**:

Patient Clothing and Effects Tag, DD Form 599, TAB J-18.

D. **CRITERIA**:

Tag is accurately completed before effects are removed from patient.

E. **STEPS**:

1. Remove tag from Admissions Packet. Ensure that both parts are intact and that each bears correct register number.

2. Fill out tag as completely as time permits.

3. Attach upper half to effects container.

4. Attach lower half to Inpatient Record Jacket.

5. Remove effects from traffic areas.

6. Patient Effects Clerk will make rounds to Casualty Receiving every 4 hours to collect accumulated effects and to deliver them to storage containers adjacent to administration.

7. Wards will notify the Patient Effects Clerk whenever effects have been removed from patients assigned to wards. Upon receipt or such notification, the Clerk will collect and store the effects appropriately.

F. **RESPONSIBILITY**:

Admitting Clerk-Patient Administration Department.

TAB C-5

INVENTORY AND STORAGE OF PERSONAL PROPERTY

A. **PURPOSE:** Provide identification and control of patient's personal valuables.

B. **DEFINITION:** A bag with an attached inventory form to record items deposited for safekeeping by Patient Effects Clerk.

C. **EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:**

Property (Valuables) Storage Tag, NAVMED 6010/8.

D. **CRITERIA:**

Inventory record is accurately completed, reflects bag contents and is properly stored.

E. **STEPS:**

1. Remove storage bag and deposit record form from admissions packet.

2. Inventory valuables obtained from patient and record on deposit record form.

3. Obtain patient's signature attesting to inventory accuracy.

If patient is unable to sign or to verify inventory, conduct inventory in presence of witness, and obtain witness' signature.

4. Counter sign the inventory.

5. Unless circumstances clearly preclude it, the inventory must be signed by a Commissioned Officer who has not been designated as Valuables Custodian.

6. Attach pink and blue copies to Inpatient Record Jacket.

7. Leave remaining parts intact, seal envelope, and store in controlled drugs cabinet.

8. Patient Effects Clerk will make rounds to Casualty Receiving every 4 hours. At that time, deliver accumulated valuables bags to the clerk. Latter will sign receipt for same. Remove and retain green copy.

If valuables are collected elsewhere, receiver will notify Patient Effects Clerk.

9. Valuables will be stored in a safe or locking file cabinet in Patient Administration spaces.

F. **RESPONSIBILITY:**

1. Admitting Clerk.

2. Patient Administration Clerk.

TAB C-6

PREPARING ADMISSIONS AND DISPOSITION REPORT (A&D)

A. PURPOSE: Provide a summary of admissions (gains) and dispositions (losses) from 0001 to 2400 hours each day.

B. DEFINITION: A legal record of all patient A&D transactions.

C. EQUIPMENT, SUPPLIES, AND FORMS REQUIRED: N/A.

D. CRITERIA:

Report will accurately summarize all patient transactions occurring during the previous calendar day.

E. STEPS:

1. Copy information in rough draft and return A&D Log to Registrar Division ASAP.

2. Develop report using outline below. Note the report number example in heading - No. 089-86= Julian Date and Year.

3. NATO STANAG 2132 and ABCA OSTAG 470 requirements apply whenever military personnel of NATO or ABCA countries are patients in Navy Medical Treatment Facilities (MTF).

(a) Separate listings will be included (see TAB J-26).

(b) Be sure to list diagnosis and type of case (battle casualty, disease, or non-battle injury).

(c) Death cases - include cause of death.

(d) Transfer cases - list receiving MTF and nationality.

(e) Discharges - unit and nationality of unit to which discharged.

(f) Indicate Seriously Ill (SI) or Very Seriously Ill (VSI).

(g) If hospital is operational in continental United Status (CONUS) forward a copy to: Naval Medical Command

MEDCOM 332, Washington, DC 20372-5000

4. Admission of very important persons and special interest patients will be reported as quickly as practical to the Head, Patient Administration or the Senior Patient Administration Watchstander in his absence - that person will notify the Commanding Officer of the type patient, conditions requiring admission, and status if know. Report the following:

(a) General or Flag Officers.

(b) Officers 0-6.

(c) Commanding Officers.

(d) Entertainers.

(e) Distinguished visitors and political dignitaries.

(f) Foreign National VIP.

(g) Hospital staff members.

5. A copy of the 2400 census report TAB F-27 should be delivered to the Registrar Watchstander by personnel from each ward NLT 1/2 hour from end of shift.

(a) If report has not arrived 15 minutes after the expected delivery, the ward will be called to deliver.

(b) A blank ward census report will be used by Registrar Division crossing out "Ward No." and a total census of all wards will be completed NLT 1/2 hour from the arrival of last ward report.

(c). Distribution will be:

(1) C.O.

(2) X.O.

(3) Patient Administration.

F. If using the automated system, Fleet Hospital Information System (FHIS), log into the Patient Administration system and request "REPORTS". Select the appropriate reports and run them.

TAB C-7

BED STATUS BOARD

A. PURPOSE: To maintain easily readable, current status of available hospital beds, and critical care capabilities.

B. DEFINITION: A large, pre-formatted, rapidly erasable board that displays, by patient care area, design capacity, capacity in use, and remaining capacity available.

C. EQUIPMENT, SUPPLIES AND FORMS REQUIRED:

Bed Status Board.

D. CRITERIA:

Board is updated every 30 minutes to accurately reflect occupied and available capacity.

E. STEPS:

1. The Registrar Watch will update the bed status board as reports of patient movements are received from:

   (a) Casualty Receiving (Admissions Watch).

   (b) OR Prep & Hold (Nursing Staff).

   (c) Operating Rooms (Nursing Staff).

   (d) ICUs (Nursing Staff).

   (e) Wards (Nursing Staff).

2. The Registrar Watch will foot and crossfoot the board every 30 minutes and report the locations of available beds to the Admissions Watch.

3. Patient movements will be noted on the appropriate copy of the Admission and Disposition Form on file in Patient Administration.

4. The board will be used as the source for information provided to theater medical regulating activities.

5. If using the automated system, Fleet Hospital

Information System (FHIS), log into the Patient Administration system and request "REPORTS". Select the appropriate reports and run them.

G. RESPONSIBILITY:

Registar Watchstander.

TAB C-8

MEDICAL EVACUATION

A. PURPOSE: To expeditiously relocate a patient who has been stabilized but is not expected to return to duty within the current theater evacuation policy. To transfer a patient who requires treatment beyond Fleet Hospital capabilities to a facility having required capabilities.

B. DEFINITION: N/A .

C. EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:

	NUMBER	TAB	TITLE
1.	FHF 6001	H-1	Evacuation Worksheet
2.	FHF 6004	H-20	Evacuation Request
3.	DD Form 602	H-7	Patient Evacuation Tag
4.	DD Form 601	H-8	Patient Evacuation Manifest
5.	DD Form 600	H-5	Patient Baggage Tag
6.	SF 502	H-26	Narrative Summary

D. CRITERIA:

1. Patients are evacuated in a timely fashion.

2. All required records and effects depart with the evacuee.

E. STEPS:

1. When a patient's condition requires evacuation, the attending physician will:

(a) Complete the first section of the Patient Evacuation Worksheet, FHF 6001, identifying the patient, primary diagnosis, all other significant diagnoses, evacuation priority, and class (TAB C-8, Appendix 2), and any special considerations such as life/physical support equipment, special diets, and medications that must accompany the patient. (A sample worksheet is at TAB

F-1.)

(b) Sign the worksheet and obtain Department Head approval. Should such approval be verbal, that fact may be noted on the worksheet in place of any actual signature.

(c) Enter appropriate evacuation orders in the patient's inpatient treatment record.

(d) Provide the partially completed worksheet to the charge nurse.

2. The Charge Nurse will then:

(a) Notify the Patient Affairs Department, Patient Personnel Division Watchstander.

(b) Complete Section 2 of the Patient Evacuation Worksheet (TAB F-1).

(c) Sign and transmit to Patient Personnel Division.

(d) Initiate actions to comply with attending physician's evacuation orders.

3. The Patient Personnel Watchstander will then:

(a) Prepare an Evacuation Request, FHF 6004 (TAB F-20).

(b) Deliver to communications and request notification when transport ETD is identified.

(c) Initiate Patient Evacuation Tag, DD Form 602.

4. Upon receipt of ETD from transport activity the Patient Personnel Watchstander will:

(a) Report the ETD to cognizant nursing staff and command duty officer.

(b) Prepare Patient Evacuation Manifest, DD Form 601.

(c) Obtain any stored effects and valuables, note tag numbers on evacuation tag, and deliver to patient location.

(d) If appropriate, brief patient on the reason for, the process, routing and duration of the evacuation.

5. The Charge Nurse will:

(a) Assemble any effects not previously stored. Tag and provide to Patient Personnel Watchstander (PPW).

(b) Assemble any accompanying supplies, medications and equipment, and provide to PPW. Medications and consumables must be sufficient to support the patient for 3 days.

(c) Review Appendices 1 and 2 to this TAB and take actions and precautions applicable to the patient's condition.

(d) Identify medical attendant to accompany patient and PPW to departure point.

6. The attending physician will:

(a) Prepare a narrative summary, SF-502, and insert in Inpatient Treatment Record.

(b) Write discharge orders.

7. One hour prior to EDT, the Patient Personnel Watchstander will:

(a) Review, close, and stage records with the patient.

(b) Stage tagged baggage with the patient.

(c) Stage supplies, medications, and equipment with the patient.

(d) Complete the evacuation tag, obtain attending physician's signature, and secure to patient.

(e) Complete evacuation worksheet, obtain required signatures, and attach to Inpatient Treatment Record.

(f) Deliver patient, equipment, supplies, medications baggage and manifest to departure point.

8. In the automated system, FHIS, a patient evacuation roster is available. When the patient regulating module is engaged, a floppy disc will be sent to the regulating team with all necessary information needed to regulate patients effectively. The regulating team will send back a floppy disc with all necessary evacuation information for each patient.

TAB C-8

APPENDIX 1

EVACUATION CLASSIFICATION AND MOVEMENT CODES

A. CLASSIFICATIONS.

1. The classification is determined by the physician at the originating facility according to OPNAVINST 4630.9C (tri-service). Patient classification is critical in identifying to the medical aircrew whether a patient must travel on a litter or in ambulatory status, and whether able to assist themselves during an aircraft emergency. The classification categories are as follows:

Class 1 - Neuropsychiatric Patients.

1A - Acutely ill psychiatric patients who require close supervision. These patients must be sedated before a flight, restrained by leather ankle, and wrist restraints, dressed in hospital clothing, and on a properly prepared litter.

1B - Moderately ill psychiatric patients. These patients should be sedated before a flight, dressed in hospital clothing, and on a correctly prepared litter. Restraints will be provided by the originating facility and available for use if necessary.

1C - Ambulatory psychiatric patients who are cooperative and have proved reliable under observation.

Class 2 - Litter patients (other than psychiatric patients.) If patients require a rest during long flight because of recent surgery or have difficulty safely ambulating, that should be classified as litter patients.

2A - A litter patient who may not, or cannot, ambulate and who is unable to help self in an aircraft emergency. Patient should be dressed in hospital clothing and on a properly prepared litter.

2B - A litter patient who is able to ambulate and sit in a aircraft seat if seat is available. The patient is enplaned and deplaned on a properly prepared litter and should be dressed in hospital clothing.

Class 3 - Ambulatory patients (non-psychiatric). These patients may require some medical treatment, care, assistance, or observation during flight.

Class 4 - Ambulatory patients (non-psychiatric). Patients who require no care in-flight.

Class 5 - Medical Attendant (physician, nurse, corpsman). Attendants who are in addition to the basic aeromedical crew.

Class 6 - Nonmedical attendant.

B. MOVEMENT PRECEDENT.

1. The movement precedent will determine how quickly the patient will be picked up and moved by the AE System. It is determined by the physician at the originating facility. Precedents are "urgent", "priority," "routine," and "special."

(a) URGENT - patients who require emergency movement to save life or limb or prevent serious complications. Aircraft will be launched or diverted to pick up and deliver patient to destination as soon as possible, (Psychiatric patients are never "urgent").

(b) PRIORITY - patients require prompt care not available locally. Patients will be picked up within 24 hours and delivered with the least possible delay (may experience several stop en route.)

(c) ROUTINE - patients will be picked up when possible and moved on routine or scheduled flights that may involve 1 or more transit days and layovers in holding facilities.

(d) SPECIAL - any patient considered to be at

significant
risk while being aeromedically evacuated. A "special patient" may be of routine precedence whose movement may not be time sensitive but who may require special expertise or teams, special nursing care, special equipment, or special procedures.

TAB C-8

APPENDIX 2
EVACUATION PREPARATION GUIDE
INDEX

A. PATIENT REPORTING GUIDE OUTLINE.

1. PELVIC FRACTURES.

(a) Is the patient in traction? If so he should be in Collins traction. If the hospital doesn't have Collins traction, make a note that Collins traction will be applied on the flight line.

(b) Date of the injury and how it occurred.

(c) Does the patient require special handling?

(d) Does the patient have a Foley catheter?

(e) Does the patient have other medical problems?

2. EXTREMITY FRACTURES.

(a) Date of the injury and how it occurred.

(b) Is the patient in a cast or splint?

(c) Does the patient have a spica cast? ALWAYS ask this for fractured femur.

(d) Is the patient on crutches? If so, the patient should be classified SDB.

(e) How long since the injury? How long has the cast been in place?

(f) Any associated circulatory problems?

(g) If injury occurred in less than 48 hours, the cast should be hivalved prior to airlift at the discretion of the orthopedic physician.

(h) Last bowel movement.

3. BLOOD DISEASES (Leukemias, Anemias).

(a) Date of last hemoglobin and hematocrit. Must be no longer than 24 hours pre-flight. Hemoglobin must be at least

8.5 grams. If less, contact the flight clinical coordinator.

(b) Vital signs.

(c) Is the patient bleeding now? If so, from what source?

(d) Is the patient SI or VSI? Is the patient on oxygen? If so, how much?

(e) Is there an altitude restriction?

(f) Does the patient require whole blood?

(g) Is a special medical require?

(h) Other lab work - white blood count - platelet count.

(i) Does the patient require isolation?

4. ABDOMINAL INJURIES OR SURGERY.

(a) Date of injury or surgery.

(b) Does the patient have any type of gastric tube in place?

(c) If so, to what type of suction is it connected?

(d) Are any drainage tubes in place?

(e) If so, are they connected to suction or free drainage?

(f) Does the patient have a colostomy or fistula? If so, type of bags used. Provide enough bags for duration of trip.

(g) Is the patient SI or VSI?

(h) Is the patient on a special diet? IV?

(i) Does the patient have an Ileus? Eating? Bowel movements?

(j) Is there an altitude restriction?

(k) See also No. 28.

5. SPINAL CORD INJURIES OR SURGERY.

(a) Date of injury or surgery. Areas of spine involved.

(b) Is there any paralysis or loss of sensation?

(c) Is the patient SI or VSI?

(d) Is there any respiratory problem, especially in cervical injuries?

(e) Does the patient have a Foley catheter? If not, is the patient voiding on his own?

(f) Does the patient have traction? If so, it must be Collins traction. Handle as para 1a. If hospital does not have Collins, request physician to accompany patient to flight line to supervise application of Collins traction (cervical injury).

(g) Does the patient have a special collar or cast?

(h) Does the patient have gastric or bowel distention or a paralyticileus? Does the patient have a colostomy? When was the last bowel movement?

(i) Is the patient NPO or on tube feedings?

(j) Is the patient on a Stryker frame? What type, a 6 foot or 7 foot? A wedge Stryker frame does not fit on a medical evacuation aircraft. Make sure all parts to the Stryker frame are sent with patient.

(k) Any special equipment needed?

(l) What are the current vital signs and lab results?

(m) Are there any associated head/internal injuries?

(n) Are there any pressure sores? Where?

(o) When a patient is reported for movement on a Stryker frame, it should be stressed to the Registrar of the

reporting
hospital, whether civilian or military, that a physician must accompany the patient to the flight line to supervise the application of the Collins traction.

6. AMPUTATIONS.

(a) What type of amputation?

(b) What was the date of the amputation or surgery?

(c) Reason for the amputation.

(d) Is the patient in traction? (Especially if a below
the knee amputation.) If so, ask traction question.

(e) Is the patient SI or VSI?

(f) Are there any other diagnoses?

(g) A recent amputation above or below knee should be classified as a litter.

7. BRAIN SYNDROME.

(a) Cause.

(b) Seizures? If so, ask seizure questions.

(c) Age and general mental state.

(d) Any special treatment required or other medical problems?

(e) Any elevated temperature?

(f) Any behavior problems?

8. EYE DISEASES, INJURIES, OR SURGERY (retinal detachments).

(a) Date of occurrence.

(b) What is the eye sight now?

(c) Eye patches? To which eye, or both eyes?

(d) Any altitude restrictions? Any air in the globe?

(e) Any medications?

(f) Must patient be kept in supine position or may he turn his head from side to side?

9. PSYCHIATRIC PATIENTS.

(a) Date of admission and circumstances.

(b) Is the patient suicidal or homicidal?

(c) Hospital clothing and litter?

(d) Eyeglasses, combs, wedding bands, wrist bands, identification cards, wallets, and small sums of money not to exceed $25 can be carried if the attending physician approves.

(e) No cigarette lighters, razor blades, matches, etc., can be carried.

(f) Class 1A patients must be restrained and medicated pre-flight; class 1B patients must be medicated pre-flight and have restraints available.

(g) Patients should be briefed by hospital, if possible.

10. CARDIOVASCULAR SYSTEM (heart disease, myocardia infarction, coronaries).

(a) Date of myocardia infarction (MI) (contact the flight clinical coordinator if under 14 days post MI), part of heart damaged or date and findings of coronary study.

(b) Current and past medical problems. Any pulmonary disease, diabetes, hypertension, cardiac disease, or renal disease?

(c) What symptoms is the patient currently having? For example, is there any edema, fainting, shortness of breath, sleeping with head elevated, palpitations, hemoptysis (spitting up of blood), or discoloration of extremities?

(d) Does the patient have any pain? What type? Where? If the patient has chest pain does he get it with or without activity?

(e) What medication is the patient currently taking? Anti-coagulants?

(f) Activity permitted? (Bed rest, dangle legs, walking as tolerated (how far), bathroom privileges only, able to climb stairs.) If patient is unable to climb stairs and walk long distances, he must travel on a litter.

(g) What are the current vital signs?

(h) Any altitude restrictions?

(i) Is the patient SI or VSI?

(j) How old is the patient?

(k) Will oxygen be required in flight? Does the patient use oxygen in the hospital?

(l) Is the patient fit to fly without the attendance of a physician?

(m) Lab studies - HGM, MCT, PT, or PTT clotting profile, cardiac enzymes, glucose, or electrolytes.

(n) Chest X-ray.

(o) Has the patient had a cardiac catheter, EKG, or arteriograph.

(p) Any stop/time restrictions?

(q) Is the patient on the cardiac monitor? Is the monitor required for flight and what is the patient's cardiac rhythm?

11. PACEMAKER.

(a) Where is the electrode placed? (Myocardiac - usually two lead wires inserted directly into heart muscle. Endocardial - one lead wire threaded down through neck vein into the heart.)

(b) Type - Continuous (fixed rate), synchronized (variable rate), demand, or radio frequency pacemaker. The radio frequency type is an older type and not good for A/E.

(c) Date inserted.

(d) Rate.

(e) Current vital signs.

(f) Any problems with the pacemaker?

(g) Is the cardiac monitor required?

12. GASTRIC OR DUODENAL ULCERS.

(a) When was the last episode of bleeding?

(b) If the patient is currently bleeding, a hematocrit and hemoglobin must be done no longer than 24 hours prior to flight. The hemoglobin must be at least 8.5 grams. If it is lower and the hospital still wants to fly the patient, contact the flight clinical coordinator.

(c) Is blood required?

(d) Does the patient have gastric tube? It is connected to suction?

(e) Did he have a gastric tube? When was it removed?

(f) Did the patient have surgery for an ulcer?

13. ACCIDENTAL INJURIES.

(a) Ask about all injuries sustained, even though only one diagnosis may be given.

(b) Date of injuries.

14. PULMONARY DISEASE OR SURGERY.

(a) Diseases other than tuberculosis.

(1) Is the patient in respiratory distress now? What

is latest blood gas report?

(2) Is oxygen needed?

(3) Are there any altitude restrictions?

(4) Is the patient SI or VSI?

(5) Is a ventilator required? If patient is on a ventilator, get name and type.

(6) Is any other special equipment required?

(7) Pneumothorax patients. Does the patient have chest tubes? If so, is pleur evac required? Is the Heimlich valve connected? If not, it will be needed for flight. To what type suction are they connected? Has the patient had chest tubes? What date were they removed? Date of last x-ray. What is percentage of expansion of affected lung?

(8) Any stop/time restrictions?

(b) Tuberculosis. Is the disease active, active but not contagious, arrested, or suspected? Is there a recent chest x-ray or skin test? What were the results? All active infectious or suspected TBC are carried on a litter and isolated. Tell hospital to brief patients regarding this situation. Arrested or active but non-infectious TBC patients require no isolation and may be ambulatory.

(c) Chest Surgery.

(1) Date of surgery.

(2) Respiratory distress now?

(3) Is oxygen needed?

(4) Are there any altitude restrictions?

(5) Is the patient SI or VSI?

(6) Is a ventilator required? What kind is the patient using if using a ventilator?

(7) Is any other special equipment required?

(8) See 14a(7) above.

(9) To what type of suction are they connected? Heimlich valve must be in place-underwater drainage. Pleur evac is required.

(10) If chest tubes have been removed, what date were they removed? If airlifted, chest tubes must have been removed for 24 hours prior to flight.

(11) Chest x-ray taken after removal of chest tube. Please provide x-ray interpretation/report.

15. PULMONARY EMBOLUS.

(a) When admitted and why?

(b) When did pulmonary embolus occur and symptoms?

(c) Symptoms at this time.

(d) Cardiac status. EKG changes?

(e) Chest x-ray about 24 hours after embolus atelectasis is noted.

(f) Any anticoagulant treatment? Results for coagulation time or PTT.

(g) Current HGM & HCT.

(h) Any evidence of bleeding? Urinalysis, occult blood in stool, or vomitus?

(i) Current vital signs.

(j) Blood gases (were they done on room air or oxygen)? If done on oxygen what percentage?

(k) Does the patient require sedation?

(l) Is the patient on any medications?

(m) Any other medical problems or surgery?

(n) Is the patient on oxygen? How much and how administered?

(o) Current level of activity.

(p) Any respiratory distress? Any dyspnea at rest?

(q) Any other complications?

(r) Any altitude restrictions?

(s) Is the patient SI or VSI?

16. CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD).

(a). Type.

(1) Chronic bronchitis.

(2) Asthma.

(3) Emphysema.

Death is often related to acute bronchopulmonary infection. Often organized pneumonia or scarring of lung parenchyma from previous infection. Pulmonary embolism, bleeding or perforated peptic ulcer, spontaneous pneumothorax, or cardiac arrhythmias are complications.

(b) Clinical picture of patient. Is the patient short of breath? Anorexic (without appetite)? Losing weight? Fever? Chronic productive cough? Any edema? Is the patient cyanotic?

(c) Blood gases - room air or oxygen? If on oxygen what percent?

(d) Chest x-ray. When?

(e) Pulmonary function studies. When?

(f) Any complications? For example, peptic ulcers, recurrent infections, respiratory acidosis, pneumothorax, status asthmaticus, or cardiac?

(g) Medications.

(h) Does patient get IPPB treatments? With what solution? How often?

(i) Any other medical problems?

(j) Is patient being given any oxygen? How much? How?

(k) Current vital signs.

(l) Any stop/time restrictions?

(m) Any altitude restriction?

17. SEIZURE DISORDERS.

(a) Cause of seizures. Epilepsy, head trauma, or infection?

(b) Type of seizure.

(c) Does the patient have an aura? (Pre-seizure symptoms manifested.)

(d) Does the patient have a loss of consciousness? Incontinence of urine or stool? Profuse salivation?

(e) How long does it last? How often do they occur? Type of body movements. Level of activity immediately following seizure.

(f) Date of last seizure.

(g) How many seizures has the patient had in the last 24 hours?

(h) What medication is the patient currently taking?

(i) Any other medical problems, especially heart, or lung?

(j) Current vital signs.

(k) HGB or HCT.

(l) Have the physician order medication PRN should the patient have a seizure in flight.

18. EXACT DIAGNOSIS UNKNOWN/SUSPECTED DIAGNOSIS.

(a) When was the patient admitted?

(b) What symptoms does the patient have?

(c) If the suspected diagnosis is neurological, ask if the patient has seizures. If the patient has seizures, ask the seizure questions in para 17.

(d) If the suspected diagnosis is TBC or "rule out TBC' remind the hospital to send patient on a litter and masked. Remind them to brief the patient.

19. CEREBRAL VASCULAR ACCIDENT (CVA OR STROKE).

(a) Does the patient have partial or complete paralysis (paresis, hemiplegia, quadriplegia, paraplegia)?

(b) Does the patient have loss of functions, voluntary muscle movement, or sensation, weakness, headache, speech difficulty?

(c) Does the patient have spasticity?

(d) Date of the accident and a brief history of how the patient was presented.

(e) What are the current vital signs?

(f) What is the cardiac status?

(g) Is the patient SI or VSI?

(h) Is the patient NPO or on tube feedings, special diet, need to be fed?

(i) Is any special equipment needed?

(j) What is the patient's age?

(k) Is the patient fit to fly without the attendance of a physician?

(l) Does the patient have a Foley catheter?

(m) Is there any respiratory distress?

(n) Does the patient have a tracheostomy?

(o) Is the patient conscious? If yes, is there any confusion?

(p) Why is the patient being air evacuated?

(q) Patient should not be airlifted for 3 to 6 weeks post CVA. If sooner than 3 weeks post CVA, bring to the attention of the flight clinical coordinator.

20. MANDIBLE, MAXILLA, AND OCCASIONALLY ZYGOMA FRACTURES.

(a) Date of injury.

(b) Are the jaws wired?

(c) If the jaws are wired, does the patient have a quick release type of fixation? (375 AAWM 164-1) If no quick release, contact flight clinical coordinator.

(d) What type of diet?

(e) Does the patient have a tracheostomy? If so, when was the tracheostomy done? Type of tracheostomy tube in place.

21. SKULL FRACTURES.

(a) Date of injury. Brief history of how it occurred.

(b) State of consciousness.

(c) Neurological and vital signs.

(d) Any paralysis or spasticity?

(e) Is there spinal fluid draining from the nose or

ears?

(f) Any special equipment needed?

(g) Does the patient have a tracheostomy? When was the tracheostomy performed? Type of tracheostomy tube in place?

(h) Does the patient have a Foley catheter?

(i) Collins traction?

(j) Any altitude restrictions?

(k) Is the patient NPO or on tube feedings?

(l) Is the patient SI or VSI?

22. AMBULATORY PATIENTS WITH BRACES AND CASTS.

(a) Can the patient sit comfortably for long periods of time? If not, classify as 2A.

(b) Does the patient need to have extremity elevated?

IMPORTANT - Patient may take two seats.

(c) Is the patient dependent on crutches? If so, must be on a litter.

23. ELEVATED TEMPERATURES.

(a) When was the onset of the fever?

(b) Suspected cause. Is isolation required?

(c) Is medication given to control temperature? If so, what drug?

(d) Is temperature controlled by ice packs, sponges, or hypothermia blanket? If so, be sure to notify the flight clinical coordinator.

24. CHILDREN.

(a) Age and sex.

(b) Is infant in arms or on a litter? If in arms, will it require bassinet and two seats (one for infant and one for attendant)?

(c) Special diet or formula? Send with patient if formula.

(d) Requires non-medical attendant if under 12 years old.

(e) Requires a letter of consent if no attendant.

25. PATIENTS LIABLE TO HAVE ALTITUDE RESTRICTIONS.

(a) Respiratory problems.

(b) Cardiacs.

(c) Chest diseases or surgery.

(d) Intracranial tumors.

(e) Recent CVA.

(f) Trapped gases in skull, chest, or abdomen, or any trapped gas.

(g) Blood diseases.

26. PATIENTS WITH CARCINOMA.

(a) Date of diagnosis. Site of the cancer.

(b) Where is carcinoma located now?

(c) Is there any metastasis?

(d) Is patient terminal?

(e) Why is patient being airlifted?

(f) How many stops can the patient tolerate? How many RON?

(g) Lab work - WBC, HGB, chest X-ray, and vital signs?

(h) Is isolation required?

27. ALCOHOLIC PATIENT.

(a) History of delirium tremors and, if so, when was last delirium tremors?

(b) History of seizures?

(c) If DT or seizures, what type medication was given?

(d) Date of last drink.

(e) Medication order PRN for flight.

28. POSTOPERATIVE CONDITIONS.

(a) Date of surgery.

(b) Type of surgery performed.

(c) Is the patient SI or VSI?

(d) Is the patient NPO, receiving IV, and or diet?

(e) Does the patient have a gastric tube? Is it connected to suction?

(f) Did he have a gastric tube? When was it removed?

(g) A 12 day postoperative period is recommended for airlift. If earlier movement is requested, contact the flight clinical coordinator.

(h) Any other medical problems?

29. HERNIA.

(a) Date of surgery. When diagnosis made?

(b) Type of hernia.

(c) Has the patient had chest pain previously or respiratory distress?

(d) Is there any trapped gas present?

(e) Has the hernia been reduced? If patient must be airlifted and has a large hernia, should have hernia reduced prior to flight if possible.

30. RENAL FAILURE/RENAL DIALYSIS PATIENTS.

(a) Laboratory work:

(1) Hemoglobin (if less then 8 gms, or Hct less than 25 percent, contact the flight clinical coordinator.)

(2) BUN (Blood urea nitrogen).

(3) Creatinine.

(4) Sodium.

(5) Potassium.

(6) Chloride.

(7) CO_2.

(8) SGOT.

(9) Specific gravity of urine.

(10) Urea.

(b) Cardiac status - current EKG (the last 1 to 2 hours).

(c) Urinary output per 24 hours.

(d) Special diet or fluid restriction.

(e) Current vital signs.

(f) Any edema?

(g) Is patient on renal dialysis? (If on dialysis, contact the flight clinical coordinator.)

(1) How often is dialysis done? Specify days of week.

(2) When was dialysis started?

(3) Does the patient have a shunt, if so, what type, and where is it located?

(h) Any other medical problems? For example, pulmonary edema, GI bleeding, infection, and/or hepatitis.

(i) Is the patient on IV? Type. How? Is it a CVP line?

(j) What is the level of consciousness? Response to pain, neurological signs, any uremic frost on skin?

(k) Is patient ambulatory? If reported as ambulatory patient, is patient able to walk long distances, and up steps?

(l) Has patient had surgery? What? When?

(m) What is purpose of A/E move?

31. BURN PATIENTS.

(a) Percentage of total body surface burned.

(b) How was patient burned? Date burned? What are current vital signs?

(c) Is patient SI or VSI? Major areas of burn.

(d) What IV fluids are being used? How much?

(e) Does patient have a Foley catheter? What has output been running every hour?

(f) Does patient have a nasal-gastric tube? Any suction needed?

(g) Does patient have a tracheostomy or endotracheal tube? Size of tube being used?

(h) What type of dressing?

(i) Is patient on antibiotics? What?

(j) Is sedation necessary? What medication?

(k) Is topical treatment to burn in progress?

(l) Is patient alert, oriented, etc.?

(m) Is there a need for any special equipment? Is the patient on a ventilator?

(n) Does patient have any other known disease

entities?

(o) Is an altitude restriction indicated?

(p) Is a physician needed to accompany patient?

32. HEAD INJURY.

(a) Date of injury and how it occurred.

(b) Neurological observations:

(1) Level of responsiveness. Does he arouse to name, shaking, or to painful stimuli? Is he oriented to person, place, and time?

(2) Does he have any headache, double vision, nausea, or vomiting?

(3) Pupil size and shape. Reaction to light?

(4) Current vital signs.

(5) Movement and strength of extremities.

(6) Any injuries to other organ systems?

(c) Any bleeding or spinal fluid leak from eyes, ears, nose, or mouth?

(d) Was there any paralysis or flaccidity of extremities?

(e) Any seizures? Date of last seizure. How many seizures in the past 24 hours?

(1) Type of seizure. Was there any incontinence of urine or stool? Duration of seizure. Loss of consciousness? Any paralysis or weakness of arms or legs after attack? Was there an inability to speak after the attack? Does patient sleep after attack?

(2) Any aura? What is it?

(3) Treatment required to control seizure?

(4) PRN order for control of seizures in flight?

(f) Lab work, HGB, HCT, electrolytes, clotting profile, blood gases- were they done on room air or O2 (how much?), SED rate, glucose, BUN?

(g) Any trapped air in skull or chest?

(h) Chest x-ray.

(i) Cardiac status.

(j) Does the patient have a tracheostomy? When? What size and type? If cuff inflated or deflated? Is the patient on a ventilator?

(k) Does patient have an IV? What type? Where? Is CVP being measured?

(l) Does patient have a Foley catheter?

(m) Is the patient NPO or getting tube feedings? If getting tube feedings, is the tube NG or gastrostomy?

(n) Is suction needed?

(o) Any medications or treatments?

(p) Any contraindications from placing the head of the patient towards the tail of the aircraft or at a 30 to 45 degree elevation?

(q) Any altitude restrictions?

(r) Any other medical problems, such as stress ulcer, infection, diabetes, lung problems? Any associated spinal cord injuries?

(s) Intake and output?

(t) Any stop/time restrictions?

(u) Is patient stable enough to travel without a

physician?

33. VASCULAR SURGERY (ARTERIAL).

(a) Type of surgery and date?

(b) Any complications after surgery? For example, poor circulation with clotting of the graft, bleeding from graft site, acute renal failure, hypertension, infection, CVA.

(c) Cardiac status at present.

(d) Extremity circulation good or poor?

(e) Current vital signs.

(f) Are there any dressings?

(g) How is the patient's output?

(h) Are there any pulmonary complications?

(i) What is the patient's activity level? If ambulatory, is the patient able to walk long distances and climb stairs?

34. HERNIATED NUCLEUS PULPOSUS (HNP)/LOWER BACK PAIN (LBP)/LUMBAR DISC.

(a) Type of pain and date of onset of symptoms.

(b) How being treated? Bed rest, traction, collar, or brace?

(c) Medications.

(d) Is the patient able to climb stairs?

(e) Is the patient able to sit for long period of time?

(f) Any other medical problems? Heart or lung especially?

(g) Current vital signs.

(h) HGB, HCT?

(i) Did the patient have surgery? When?

35. GUILLIAN-BARRE SYNDROME/ACUTE POLYNEURITIS.

(a) Date of onset of symptoms and date of diagnosis.

(b) Amount of muscle weakness. It patient over the acute phase? Any muscle tenderness, neck ache, backache, or sensory loss?

(c) Any difficulty breathing or swallowing?

(d) Any complications? Ileus? Pulmonary emboli?

(e) Any other medical problems?

(f) Does patient have a tracheostomy? What size and type?

(g) Is patient on a ventilator? What type? How long has the patient been on the ventilator?

(h) Current vital signs.

(i) HGB, HCT?

36. STOKES-ADAMS SYNDROME/FAINTING.

A deficiency of cerebral blood flow due to a slowing of the heart rate or ineffective ventricular contraction and output during tachyarhythmias. Signs and symptoms include transient faintness - blackout, dizziness, sudden syncope, convulsions, cardiac arrest, and shock.

(a) Date of diagnosis and brief history of the problem.

(b) Signs and symptoms.

(c) Current vital signs.

(d) Has patient ever had a seizure? If so, how treated?

(e) Is pulse regular?

(f) When was last attack?

(g) Is there any history of cardiac problems?

(h) Any myocardia infarction (MI)? When?

(i) Is the patient a diabetic?

37. PREMATURE/RESPIRATORY DISTRESS SYNDROME (RDS).

(a) Gestation. Type of delivery.

(b) Apgar at 1 minute? At 5 minutes? (0 to 3 very poor, 4 to 6 fair, 7 to 10 good.)

(c) Gravida and para of the mother.

(d) Mother's condition.

(1) Any known health problems?

(2) Any medication taken during pregnancy or given during labor, including anesthesia during labor?

(e) Respirations - regular or irregular? (30 to 50 average rate.) The ratio of respirations to pulse should be 1:4.
The ratio of respirations to temperature should be 4:1. (Four respirations for every 1 degree of fever over normal.)

(1) Is there expiratory grunting or whining (when infant not crying)?

(2) Any retractions? Type? Degree? (Intracostal, subcostal, and/or suprasternal.)

(3) Any nasal flaring?

(4) Any cyanosis? Is it relieved by 0_2 and how much?
What parts of the body are cyanotic?

(5) Are there areas of decreased breath sounds and where?

(6) Any rales?

(7) Any apnea? What stimulation must be used to initiate breathing?

(f) Heart rate - 70 to 170 range; average 120. Regular or irregular?

(g) Activity? Any lethargy or listlessness?

(h) Color. Any jaundice?

(i) Any abnormalities or congenital defects?

(j) Temperature. Decreases as disease progresses?

(k) Lab tests. Blood gases on room air or 02? What percentage 02? Electrolytes, HGB, HCT, blood sugar - hypoglycemia common in premature infants.

(l) Chest x-ray.

(m) Has infant had first voiding? How is urine output?

(n) Are bowel sounds present? Often absent early in illness.

(o) Any edema of hands and feet?

(p) Any resuscitation required at present?

(q) Any treatment or medicine administered?

(r) How is infant getting nutrition? Is there an IV? Where? What solution? How much?

(s) Any special equipment? Monitor? Ambu? Respirator? IV? Incubator? Suction? Other?

(t) Any altitude restriction?

(u) Any stop/time restriction?

(v) Is infant stable enough to travel without a physician?

38. LUNG DISORDERS/ADULT RESPIRATORY DISTRESS/RESPIRATORY FAILURE.

Cyanosis is difficult to assess in anemia or polycythemic patients. In order for cyanosis to be present, there must be more than 5 gms of unsaturated HGB.

(a) When was patient admitted and what were the symptoms?

(b) Etiology and/or precipitating factors?

(c) How does the patient look now? Is there any dyspnea? Restlessness? Agitation? Cyanosis?

(d) Any problem in history of chronic lung disease?

(e) Respirations - Rate. Is there any grunting? Intercostal retractions? Alveolar infiltrations? Breath sounds?

(f) Lab studies - Blood gases done on room air or 02? What percentage 02? HGB, HCT, or electrolytes?

(g) Current chest X-ray.

(h) Any complications? For example, 02 toxicity? Sepsis? Fluid imbalance? Injury for tracheostomy and suctioning?

(i) Does patient have a tracheostomy? Endotracheostomy tube? How often does he need suctioning? What color is the sputum?

(j) Current vital signs.

(k) Is the patient on a respirator? What type?

(1) Respiratory rate of respirator.

(2) Tidal volume.

(3) Percentage 02.

(4) Is PEEP or CPAP being used? How much?

(l) If patient is on PEEP or CPAP (continuous positive airway pressure). Any complications? For example, decreased cardiac output, subcutaneous emphysema pneumomediastinum, pneumothorax? If patient is to be transported on MA-1, has the doctor accompanying patient ever used the MA-1? Does he feel comfortable using MA-1?

(m) Is patient on cardiac monitor? What is cardiac status? Any previous cardiac problems?

(n) IV? Type? How much? Is CVP being measured?

(o) Any medication?

(p) Any evidence of bleeding?

(q) Neurological status:

(1) Level of consciousness.

(2) Motor reflexes.

(3) Response to pain.

(4) Neurological signs.

(r) Renal system. How is output? Any signs of infection?

(s) Any altitude restriction?

(t) Any stop/time restrictions?

TAB C-9

DECEDENT AFFAIRS

A. PURPOSE: To provide an outline to follow when a death occurs in or upon arrival at a Fleet Hospital. Detailed guidance may be found in BUMEDINST 5360.1D, Decedent Affairs Manual.

B. DEFINITION: The term "Death" includes both those patients who die during a period of hospitalization or those who are pronounced "Dead On Arrival" (DOA) at the hospital.

C. EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:

1. Certificate of Death (Overseas), DD Form 2064.

2. Death Tag, DD Form 3910.

3. Serious/Very Serious Condition or Death of Patient on Ward, NAVMED 6320/5.

4. Human remains pouch.

5. Record of Personal Effect (2 sides), DD Form 1076.

D. CRITERIA:

1. Remains are properly prepared and identified.

2. Required notifications are made.

E. STEPS:

1. When a death occurs, the attending physician will:

(a) Make appropriate entries to close the Inpatient Treatment Record.

(b) Prepare and sign Certificate of Death, DD Form 2064.

2. The responsible Nursing Staff member will:

(a) Notify the Patient Personnel Division, Decedent Affairs Watch and the Command Duty Officer.

(b) Attach the completed Death Certificate to close the Inpatient Treatment Record.

(c) Initiate the hospital Report of Death.

(d) Inventory, and secure deceased's valuables. (TAB C-5)

(e) Inventory and secure deceased's personal effects. (TAB C-4)

(f) Prepare 2 death tags.

(g) Attach 1 death tag to remains.

(h) Insert remains in human remains pouch, seal, and attach second death tag securely to pouch.

(i) Deliver remains to the established morgue.

3. The Decedent Affairs Watchstander will:

(a) Obtain the Inpatient Treatment Record and Death Certificate.

(b) Obtain inventoried valuables and effects and prepare DD Form 1076.

(c) Complete the Hospital Death Report and actions required by it.

(d) Prepare required message notifications (TAB F-25).

(e) Prepare effects and valuables for disposition as directed by cognizant Graves Registration authority.

(f) Take actions directed by concurrent return or graves registration authority to dispose of remains.

TAB C-10

COLD WEATHER PROCEDURES

A. PURPOSE: To detail procedures for cold weather operations.

B. DEFINITION: Cold weather operations occur in environments where temperatures range to -10 degrees fahrenheit.

C. GENERAL PLAN AND PERSONNEL ITEMS:

1. Exposure to freezing weather will cause damage to many medicinals and liquids. Prior to mobilization the supply officer should be directed to identify those items susceptible to freezing or cold damage during transit and set up of the hospital. A plan must be developed to protect these items from freeze damage. Collect and store identified items in a temperature controlled area until required.

2. During construction augment the supply officer with team(s) including an experienced officer and senior petty officer to act as materials locator (expeditor).

3. Identify and equip warming tents. Assign MAA personnel to keep warming area from becoming congested and to ensure that hot wet items (decaffeinated tea, coffee, soups or hot cool aid) are replenished.

4. Many temper and other construction tasks cannot be easily done while wearing protective clothing and this increases risks of harmful exposure to cold. Personnel involved in heavy work will have to shed clothing layers. Brief personnel on hazards. Best protection for the hands are leather work gloves with wool inserts. Scheduled work breaks for warming and hot wets should be enforced.

5. Proper supervision of work crews will be rewarded by efficiency and healthy personnel for later operation of the hospital. Even with good leaders and personnel work

efficiency during cold weather will be degraded by perhaps 25 percent over production in temperate environments.

D. TEMPER TENT CONSTRUCTION:

1. Site planning should take into consideration spring thaw runoff, frost heave, snow drifting, drainage inside and around heated tentage, associated problems of mobility, freeze effects on equipment containing water and on patient and personnel.

2. Placement of the tent pegs in frozen ground will be easier if an electric drill and 1 1/2 inch auger is used to drill past the frost line. Water poured into the hole will quickly provide a firm anchor until spring thaw. Tent pegs will quickly pull out in run-off softened ground in spring. Anchor with 2-3 sand bags. Protect tent pegs from snow removal equipment by placing 5-6 ft bamboo poles with red flags attached near outside perimeter of tents to identify the roadway to be plowed.

3. Guy lines should be installed with the tent slips near the eave extender and not the tent peg. This arrangement will make it easier to adjust the tension when snow depth increases and covers the tent peg.

4. Rope handling and bucket lacing will be difficult with gloves provided in FH allowances. Workers must be cautioned about touching metal and exposure to extreme cold.

E. PLACEMENT OF STATIONARY OUTSIDE EQUIPMENT:

1. A/C, heating equipment and electrical panels should be placed on blocking material to keep it from freezing to ground.

2. Ensure that electrical connections are securely fastened, protected and readily locatable (use flags or other devices to identify).

3. Potable and waste water line connectors/fittings must be completely protected by the provided insulated material. Wrap with duct or plastic tape because the adhesive tends to not

stick
as planned.

4. Sewage ejector must be protected from freezing by lowering the lower limit or burying the box.

5. Oil fired heaters may be a problem if left outside and not used due to snow and water freezing up the blower. In addition you should have a designated person to oversee repairs
and become the expert. Special problems include burner nozzles
and blowers.

F. <u>GENERAL PURPOSE TENT</u>:

1. GP large tents require much greater maintenance than other types. The off set poles and corresponding longer side will allow greater accumulations of snow and water melt and thus
increase the pressure on the stakes on the long side. 61% of the
snow load will gather on the long side. Watches must be established to ensure that snow removal operations continue through out snow storms. Depths of 3-4 inches of wet snow should
be considered as maximum in unheated tents. Heated tents will be
accumulating the melt water at the same relative rate and will require dumping of the water.

2. Use frozen snow banks created by snow removal to insulate
edges of tents. Create run off channels to guard against pooling
of melt water from roofs.

3. Sand bags must be used to anchor tent pegs during spring
thaw. 2-3 bags will be required for each peg on the long side of
the GPL.

G. <u>FLOORING</u>:

1. Walk ways made of pallets or flooring must be provided for laundry, food service and other areas that regularly are wet.
Suggested methods are double sleepers constructed of 2 by 4s with
staggered joints and covered with sheets of 1/2 inch plywood.
15

Inch 2 by 4s support joints between the plywood.

2. Spring thaws will create pools of water under insulated flooring. Corrective measures include providing drainage and escape passages for the built up snow around the tent eaves.

3. Employ mats at the entrance ways to temper tents for scraping soil or water off feet. Helps to prevent tracking into the wards/wings.

H. MAINTENANCE OF TEMPER TENTS :

1. Use provided snow rakes to remove accumulations of snow on roofs of over 3 inches. If snow continues to accumulate round the clock removal should be instituted for accumulations of over 2-3 inches.

2. Experience has shown that removal of eve extenders, will make removal of snow easier. Use bent 12d galvanized nails inserted in the holes at the top of the frame eave spindles to make sure that the flies stay in place.

3. A maximum height of 5-6 foot of removed snow buildup at the sides of the tent is best. The remainder should be scooped outboard to avoid bulging of the tent sides and to facilitate roof snow removal.

4. Doorways along the sides of the temper tent require 25% greater expenditure of effort than a roof section.

5. With wall bulges from snow accumulation beds will have to be moved as much as 6 inches inboard thereby creating passageway problems.

6. Removal of old snow banks will require picks and scoop shovels.

7. Snow or ponded water on vestibules must be removed to avoid dripping caused by leakage at seams.

8. Inspect snow rakes for burrs or dents to avoid ripping

temper fabric. Burrs can be removed by filing smooth.

9. Vestibules may be more affected by frost heave displacements because they are unheated and will cause the kick plate to raise as much as 4-5 inches and cause alignment problems for bump through doors. Caution must be exercised to avoid injuries.

10. Rips, tears, and damaged grommets may be repaired by sewing several layers of temper material over the tear using the tent repair kit and reinstalling zippers and grommets. Temper material will not stretch as readily in cold weather and caution should be used in matching grommets to eave and roof attachments.

I. <u>HEATING AND AIR CONDITIONING</u>:

1. Air conditioning units can supply the required 80 degree outlet air in temperatures of 25-30 degrees temperature. At lower temperatures supplemental oil fired heaters must be employed. The desired temperature at the bed level is 68 degrees fahrenheit.

2. Modesty curtains may have to be rigged to decrease the drafts at entrances and separate the active portions of the wards from storage or entrances.

3. Connect the oil fired heaters to the air conditioners (AC). The return duct of the tent should be connected to the AC, the supply duct from the AC to the return duct of the oil fired heater (OFH) and the supply duct of the OFH connected to the tent.

4. Usually the coldest part of the day is just at dawn.

5. Temper wings must have a un-insulated or plain liner installed over (inside) the insulated liners.

6. Recommended modifications to the heating system might include the following:

(a) Connect a section of un-insulated ducting to the

supply duct to deposit the hot air from the ofh to the middle of the wing. Without this extra duct much of the supply air will simply turn and enter the adjacent return duct.

(b) Install the plenum along the base of one wall rather than rigged to the overhead.

(c) Some heat escapes from the roof vents and these can be sealed with duct tape. (Recommend caution here: DO NOT TAPE ALL THE VENTS).

7. After camp set up and stabilization locate additional parts for the AC and OFH (e.g. AC bearings, fuel nozzles).

J. <u>UTILITIES</u>:

1. MSS/Base camp heads will require special care to operate in freezing conditions. All exterior exposed piping and sumps will have to be heated or insulated. The MUM, since it is connected to a temper wing and has better heating and protection will have less or no freeze problems.

2. Check to see if the potable water distribution system holds pressure. You might have to remove the check valve on the discharge side of the pump.

3. Pin hole leaks may develope in the clear two inch hose between the pump discharge and the pressure tank on the potable water system.

4. Keep glass insulation dry. Once saturated it will lose its insulation value.

5. The side covers to the toilets can be removed to expose toilet piping to warm air from the interior.

6. Mount the hot and cold water on the inside of the shelter wall under the sinks to avoid freezing.

7. The under floor water supply in the heads on the

opposite
side should be replaced to run inside the shelter near the ceiling.

8. If the laundry tent is to be left unheated all components must be thoroughly drained prior to shutting off the heat.

9. The stave tank should be kept full, drawing water from the bottom of the tank. If ice forms it must be chipped and removed.

10. The M-80 heater should be drained completely if not in use and should be supported with wood blocks to prevent freezing to the ground.

11. It must be recognized that any prolonged interruption of power to the water utilities may be more than a minor inconvenience. Destruction of all or part of the system is a reality if left exposed to freezing conditions for long. Draining of water utilities must be accomplished if extended exposure is expected.

K. <u>RESPONSIBILITY</u>:

1. Public Works Officer.

2. Department Heads.

TAB C-11

PATIENT PROCEDURES FOR HANDLING EXPATRIATED PRISONERS OF WAR

A. PURPOSE: To detail patient handling procedures for expatriated prisoners of war within the fleet hospital.

B. DEFINITION:

Expatriated prisoners of war (EPW) - those patients who require treatment who are prisoners of U.S. or allied combat forces.

C. EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:

1. Restraints (theater command military police or hospital issue).

2. Others as specified in admission procedures (all forms will be marked with the words "Prisoner of War" or "EPW").

D. STEPS:

1. Upon presentation of EPW to functional area, notify Security Department.

2. Upon admission to Casualty Receiving, Security will be responsible for the following notifications:

(a) Theater command military police(MP)headquarters.

(b) Executive Officer.

(c) Director of Nursing.

(d) Director of Administration.

2. Perform essential life saving care.

3. Inform MP that custody of patient will not be assumed by hospital staff and that MP will retain custody of EPW until relieved by appropriate MP headquarters staff or patient is transferred to EPW holding center (external to hospital).

4. After treatment, have corpsman or litter bearer escort MP and EPW to next functional area charge nurse. Admissions packet,

correctly annotated will be delivered by hand to charge nurse.

5. During course of treatment, patient will be guarded by MP and/or restrained until treatment is terminated.

6. Movement to another functional area will be reported to Security.

7. EPW's will be fed either on the ward or in the general mess. If allowed to eat in the general mess, EPW's will be accompanied by MP guards.

E. <u>RESPONSIBILITY</u>:

CMAA/Security.

TAB C-12

PROCEDURES FOR RELEASE OF MEDICAL INFORMATION

A. PURPOSE: To provide procedures of release of medical information within the hospital.

B. DEFINITION: Medical Information - Information contained in the health or dental record of individuals who have undergone medical examination or treatment.

C. EQUIPMENT, SUPPLIES, AND FORMS REQUIRED: N/A.

D. STEPS:

1. Upon presentation of requests for medical information refer to procedures contained in the following references:

(a) Manual of the Medical Department, Chapter 23.

(b) Freedom of Information Act, BUMEDINST 5720.8.

(c) Personal Privacy and Rights of Individuals Regarding Records, SECNAVINST 5211.5.

(d) Availability of Navy Records, Policies, SECNAVINST 5720.42.

E. GENERAL GUIDELINES:

1. Information contained in health care records of individuals who have undergone medical or dental examination or treatment is personal to the individual and is therefore considered to ba of a private and confidential nature. Information from such health care records, the disclosure of which would constitute a clearly unwarranted invasion of personal privacy, should not be made available to anyone except as authorized by the patient or as allowed by the provisions of Manual of the Medical Department Chapter 23 and the Privacy Act of 1974 as implemented by SECNAVINST 5211.5 series.

2. Release of information will be coordinated by the Patient Affairs Officer.

3. Personal information of non-medical nature will not be

released.

4. Personnel in the patients chain of command may be provided with information required to conduct command business but will be referred to the Patient Affairs Office.

5. Release of information will conform to local command and superior command policy.

6. All Department Heads shall ensure wide dissemination of this information and compliance with procedures outlined herein.

F. <u>RESPONSIBILITY</u>:

1. Director of Administration.

2. Patient Affairs Officer.

3. Charge Nurse or Assistant.

TAB D

STANDARDS AND JOB DESCRIPTIONS

INDEX

TAB D-1.1

HEAD, PATIENT ADMINISTRATION DEPARTMENT

The Head, Patient Administration is responsible for all patient records, valuables, evacuation, and discharge of patients.

THE HEAD, PATIENT ADMINISTRATION DEPARTMENT WILL:

1. Set policies and procedures for Patient Administration for the hospital.

2. Supervise work performance of all personnel in each division of Patient Administration.

3. Approve all communications within and outside department.

4. Act as hospital Medical Regulating Officer. As MRO the following will be accomplished:

(a) Monitor surgical backlog.

(b) Monitor morgue activity.

(c) Advise Jamro and higher headquarters of patient status and evacuation requirements daily.

(d) Ensure pre evacuation requirements are met.

(e) Coordinate evacuation of patients into and out of hospital through appropriate networks.

5. Ensure medical data not evacuated with patient is accounted for and sent at earliest date.

QUALIFICATIONS:

Hospital adminstration training is desirable.

TAB D-1.2

PATIENT ADMINISTRATION SUPERVISOR

The Patient Administration Supervisor is responsible for immediate supervision of all divisions of Patient Administration.
He report directly to Head, Patient Administration.

THE PATIENT ADMINISTRATION SUPERVISOR WILL:

1. Prepare watch schedules.

2. Supervise daily operations of all areas within the department.

3. Prepare evaluations on all enlisted personnel within the
department.

4. Ensure all personnel maintain training within job classifications.

5. Appoint Leading Petty Officers within each division.

6. Review and correct any reports or requests sent to Head,
Patient Adminstration.

7. Act as Head, Patient Administration in his absence.

8. Ensure all regulations pertaining to Patient Administration are kept current and all interested parties are advised of changes.

9. Coordinate with departments, such as Casualty Receiving,
the utilization of Patient Administration personnel in those spaces.

QUALIFICATIONS:

1. Be able to assume any other duties within the department.

2. Course in Patient Administration desirable.

3. Rate training for HMC.

TAB D-1.3

PATIENT ADMINISTRATION CLERK

The Patient Administration Clerk is responsible for maintaining all records and files related to Patient Administration, reports, and procedures.

THE PATIENT ADMINISTRATION CLERK WILL:

1. Check for correctness and completeness of all medical information, and patient personal data upon admission to the hospital.

2. Prepare reports as required by current regulations and as directed by Patient Administration Supervisor.

3. Maintain patient records.

4. Prepare records for evacuation with patient. Check for completeness of information and accuracy.

5. Coordinate with Administrative Services, the correction of any pay, personnel, or logistical problems of patients as directed.

6. Prepare admissions packets in advance in sufficient number for two days projected patients.

7. Ensure all necessary forms are maintained in supply in sufficient number to include the time required for delivery of resupply.

QUALIFICATIONS:

Rate training.

TAB D-1.4

REGISTRAR

The Registrar is responsible for maintaining current status of hospital beds and treatment spaces as well as projecting future requirements based on current tactical situations. Acts as advisor to Commanding Officer on hospital bed status and evacuation matters. He reports directly to Head, Patient Administration Department.

THE REGISTRAR WILL:

1. Ensure patient admission packets are properly assembled and on hand.

2. Verify accuracy and completeness of Admissions and Disposition log to be accomplished no less than at changing of watch.

3. Maintain bed status board. (See TAB C-7)

4. Prepare all admissions/disposition, status, and evacuation requests and reports as required by higher headquarters and JAMRO.

5. Coordinate with other sections within Patient Administration the collecting, disseminating, storage, and evacuation of patient's personal and medical data.

6. Ensure that FHIS (Fleet Hospital Information System) is operational and has been backed up.

QUALIFICATIONS:

1. Rate training for HM1 (E-6).

2. Training as hospital registrar desirable (if available).

3. Able to stand all other watches within Patient Administration.

TAB D-1.5

ADMISSIONS CLERK

The admissions clerk is assigned to Patient Administration but works in the Casualty Receiving area. He reports directly to Patient Administration Supervisor who is responsible for coordination with Casualty Receiving.

THE ADMISSIONS CLERK WILL:

1. Stand watches as designated in Casualty Receiving.

2. Fill out appropriate information on NAVMED 6300/5 as outlined in TAB F-1.

3. Admit patients to hospital as outlined in paragraph G.

4. Maintain admissions and disposition log. Make log data available to Registrar. Registrar has ultimate responsibility for log.

5. Keep adequate amounts of forms and supplies for admitting purposes available at all times. Notify Supervisor if supplies are becoming low in enough time to ensure resupply before depletion of supplies.

QUALIFICATIONS:

Rate training for HM3 (E-4.

TAB D-1.6

PATIENT EFFECTS CLERK

The Patient Effects Clerk is responsible for the inventory, recording, storage, and release of patient valuables and effects. He reports directly to the Registrar.

THE PATIENT EFFECTS CLERK WILL:

1. Collect every four hours from Casualty Receiving, valuables, and personal effects of admitted patients.

2. Inventory valuables and effects using Deposit Record Form, when satisfied, signs sheet.

3. Maintains an alphabetical file of copies of Deposit Record Form.

4. Stores valuables in safe or locking file cabinet.

5. Releases from storage valuables and effects. (IAW SOP)

QUALIFICATIONS:

1. Rate training for SN.

2. Small arms qualification.

TAB D-1.7

MEDICAL EVACUATION COORDINATOR

The Medical Evacuation Coordinator is responsible for ensuring the proper preparation for and evacuation of patients from hospital. He reports directly to Head, Patient Administration Department.

THE MEDICAL EVACUATION COORDINATOR WILL:

1. Receive from Patient Adminstration watchstander a daily list of patients to be evacuated.

2. Coordinate evacuation or discharge with other hospital staff.

3. Request through the Hospital Registrar, evacuation of patients. (Use TAB C-8 as guide.)

4. Assigns duties to medical evacuation clerk as outlined in TAB E-8.

QUALIFICATIONS:

1. Medevac (helicopter and fixed wing) operations, capabilities, and restrictions.

2. Qualified in radio telephone procedures.

3. Proficient in medical regulating procedures.

4. Qualified in rate of HM1 (E-6).

TAB D-1.8

MEDICAL EVACUATION CLERK

The Medical Evacuation Clerk is responsible for ensuring the preparation of patients for ground or aero evacuation has been done correctly. He reports directly to the Medical Evacuation Coordinator.

THE MEDICAL EVACUATION CLERK WILL:

1. Perform tasks as directed by the Medical Coordinator.

2. Accomplish evacuation of patients using TAB C-8 as a guide.

3. Maintain and operate heliport.

4. Supervise ground ambulance operations.

5. Coordinate use of litter teams and medical attendants to and from heliport or air staging facilities.

QUALIFICATIONS:

1. Rate qualified in HM3 (E-4).

2. Radiotelephone operations.

3. Aero evac (helicopter and fixed wing) operating procedures capabilities and restrictions.

4. Ground navigation-ambulance dispatching.

TAB D-1.9

DECEDENT AFFAIRS SUPERVISOR

The Decedent Affairs Supervisor manages the handling of deceased persons until transfer can be made to United States Army, Office of Graves Registration. The Decedent Affairs Supervisor reports directly to Head, Patient Administration Department.

THE DECEDENT AFFAIRS SUPERVISOR WILL:

1. Supervise Decedent Affairs clerk.

2. Upon receipt of completed death certificate from nursing staff, ensures deceased's valuables have been properly inventoried and secured.

3. Ensure deceased's personal effects have been inventoried and secured.

4. Supervise removal of remains to morgue and preparation of reports.

5. Ensure that all required message notifications have been prepared as per TAB F-25.

6. Supervise disposition of remains by Army Graves Registration.

QUALIFICATIONS:

1. Rate training for HMC (E-7).

2. Morgue operations - familiar with references listed in TAB H.

TAB D-1.10

DECEDENT AFFAIRS CLERK

The Decedent Affairs Clerk is responsible for the recording of information and preparation of deceased prior to transfer to Army Graves Registration. He reports directly to Decedent Affairs Supervisor.

THE DECEDENT AFFAIRS CLERK WILL:

1. Check inventory of valuables and personal effects for accuracy.

2. Check death tags for accuracy and completeness and then complete death report.

3. Prepare notification messages per TAB F-25.

4. Contact Army Graves Registration for instructions on deposition of remains.

QUALIFICATIONS:

1. Rate training for HM3 (E-4).

2. Morgue operations. See references in TAB E.

TAB E

REFERENCES

PATIENT ADMINISTRATION

E-1	BUMEDINST	4650.2A 4650.7C 6000.3 6000.10 6040.34 6320.10 6320.34A 6320.36A 6320.61 6700.24F
E-2	NAVMED	P-5127.6150/10-19 6300
E-3	OPNAVINST	3100-6C 4630-9C 4650-7C
E-4	SECNAVINST	6000-3 6320.5A
E-5	ARMY	FM8-71G Series

LINE OF DUTY DETERMINATION

E-6	BUMEDINST	1910.2G 1910.3B 6120.20B AR600.33

EVACUATION OF PATIENTS

E-7	BUMEDINST	4650.2A 4650.7C 5360.1C 5360.221
E-8	NAVMED	P5115
E-9	ARMY	FM1-100 FM8-29

	MEDEVAC REQUEST PROCEDURES	FM8-35
	EVAC OF SICK/WOUNDED	AR40-350

DECEDENT AFFAIRS

E-10	BUMEDINST	5360-10 5360-24
E-11	NAVMED	P5046 P5047 FM16-5 FMFM 4-8 (FM 10-63) AR 638-1 (chng 1) FM 10-63

FIELD OPERATIONS

E-12	DEFENSE	DST-1810H-001-82
	INTELLIGENCE (MARINE CORPS) AGENCY	FMFM 4-5

TAB F

FORMS

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F-16	SF 518	BLOOD TRANSFUSION REQUEST
F-17	SF 519	RADIOGRAPHIC REPORT
F-18	DD 599	PATIENT CLOTHING AND EFFECTS TAG
F-19 104		BED STATUS BOARD
F-20 107	FHF 6004	PATIENT EVACUATION REQUEST
F-21	DD FORM 1076	RECORD OF PERSONAL EFFECTS
F-22	DD FORM 2064	CERTIFICATE OF DEATH
F-23	NAVMED 6320/5	HOSPITAL REPORT OF DEATH
F-24	DA FORM 3910	DEATH TAG
F-25 109		MESSAGE FORMATS
F-26	SF 502	NARRATIVE SUMMARY
F-27 124	FHF 6005	2400 CENSUS REPORT
F-28	SF 600	CHRONOLOGICAL RECORD OF MEDICAL CARE
F-29	SF 513	CONSULTATION SHEET
F-30	DD FORM 792	24HR PATIENT INTAKE AND OUTPUT

		WORKSHEET (SAMPLE)
F-31	DD FORM 792	24HR PATIENT INTAKE AND OUTPUT WORKSHEET (BLANK)
F-32	NAVMED 6300/1	MORBIDITY REPORT
F-33		EVACUATION FLOW CHART

TAB F-1

PATIENT EVACUATION WORKSHEET

DATE: TIME:

1. ATTENDING PHYSICIAN WILL ENTER: LAST, FIRST, MIDDLE

A. PATIENT'S NAME:

B. DIAGNOSIS: NAME
CLASSIFICATION
NUMBER

C. PRIORITY: URGENT PRIORITY
ROUTINE

D. SPECIAL REQUIREMENTS:

1. EQUIPMENT.
2. MEDICATIONS.
3. PROCEDURES.
4. DIETS.

PHYSICIAN'S SIGNATURE:

DEPT HEAD APPROVAL:

2. NURSE WILL NOTIFY PATIENT PERSONNEL SECTION THEN WILL ENTER:

A. PATIENTS RANK:

B. SSN:

C. REGISTER NO:

D. UNIT:

E. BODY WT:

F. WARD NO:

NURSE'S SIGNATURE: DATE/TIME:

DELIVER TO PPD:

3. PATIENT PERSONNEL DIVISION (WILL RETURN TO ATTENDING PHYSICIAN FOR COMPLETION OF CHECK SHEET).

A. TIME COMMO. NOTIFIED:

B. BAGGAGE TAG NO.:
C. ESTIMATED TIME OF DEPARTURE:

D. DESTINATION:

E: EFFECTS TAGGED: YES NO

A. SPECIAL RQMTS PRO.

B. DD FORM 602 COMPLD: YES NO

C. DISCHARGE ORDERED: YES NO

D. RECORD DELIVERED: YES NO

E. PATIENT MANIFESTED:

4. AUTHENTICATING SIGNATURES:

(1) WARD NURSE:

(2) ATTNDG. PHYSICIAN:

(3) PPD RELEASE:

CPO:

FHF 6001

TAB F-2

ADMISSIONS AND DISPOSITIONS REPORT NO. 089-86
PREPARED 2400 HOURS, YYMMDD

I. ADMISSIONS:
(WIA, DNBI, VSI, SI, ETC)

(ALPHABETICAL)

PATIENT NAME	GRADE	SSN	FMP	REG#	WARD	TYPE CASE	UNIT

II. DISPOSITIONS:

ENT NAME	GRADE	SSN	FMP	REG#	DISPOSITION CODE	UNIT NOTIFIED

NOTE: DISPOSITION CODE

1 = MED HOLD
2 = RDT
3 = TRANS. TO HOSP
  a. SHIP
  b. COMMZ
  c. CONUS
4 = DEATH

NAME/RANK

FHCB 0805

TAB F-3

ROSTER OF VSI/SI, SPECIAL CATEGORY PATIENTS

LEFT FACING PAGE

NAME	RANK	SSN	WARD	DATE

_____

_____

_____

_____

FHF 6002

TAB F-3

ROSTER OF VSI/SI, SPECIAL CATEGORY PATIENTS

RIGHT FACING PAGE

PLACED	DIAGNOSIS	PRESENT CONDITION	RELIGION

___

____
___

FHF 6002

TAB F-19

BED STATUS BOARD

LEFT FACING PAGE

PREOP (12)	ICU #1	ICU #2
1._____	1._____	1._____
2._____	2._____	2._____
3._____	3._____	3._____
4._____	4._____	4._____
5._____	5._____	5._____
6._____	6._____	6._____
7._____	7._____	7._____
8._____	8._____	8._____
9._____	9._____	9._____
10._____	10._____	10._____
11._____	11._____	11._____
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15._____	15._____	
16._____	16._____	
17._____	17._____	
18._____	18._____	
19._____	19._____	
20._____	20._____	

NOTE: 1. EACH WARD HAS (1) ORTHOPEDIC BED (1) TURNING FRAME.

2. IF ORTHOPEDIC BED OR TURNING FRAME IS USED IT REPLACES A REGULAR WARD BED.

TAB F-19

BED STATUS BOARD

RIGHT FACING PAGE

30 BED WARD 1	30 BED WARD 2	30 BED WARD 3	30 BED WARD 4	30 BED WARD 5	30 BED WARD 6	30 BED WARD 7
1._____	1._____	1._____	1._____	1._____	1._____	1._____
2._____	2._____	2._____	2._____	2._____	2._____	2._____
3._____	3._____	3._____	3._____	3._____	3._____	3._____
4._____	4._____	4._____	4._____	4._____	4._____	4._____
5._____	5._____	5._____	5._____	5._____	5._____	5._____
6._____	6._____	6._____	6._____	6._____	6._____	6._____
7._____	7._____	7._____	7._____	7._____	7._____	7._____
8._____	8._____	8._____	8._____	8._____	8._____	8._____
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10._____	10._____	10._____	10._____	10._____	10._____	10._____
11._____	11._____	11._____	11._____	11._____	11._____	11._____
12._____	12._____	12._____	12._____	12._____	12._____	12._____
13._____	13._____	13._____	13._____	13._____	13._____	13._____
14._____	14._____	14._____	14._____	14._____	14._____	14._____
15._____	15._____	15._____	15._____	15._____	15._____	15._____
16._____	16._____	16._____	16._____	16._____	16._____	16._____
17._____	17._____	17._____	17._____	17._____	17._____	17._____
18._____	18._____	18._____	18._____	18._____	18._____	18._____
19._____	19._____	19._____	19._____	19._____	19._____	19._____
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NOTE: 1. EACH WARD HAS (1) ORTHOPEDIC BED (1) TURNING FRAME.

2. IF ORTHOPEDIC BED OR TURNING FRAME IS USED IT REPLACES A REGULAR WARD BED.

TAB F-19 (continued)

(PLACE BELOW PREOP ON BOARD)

CASUALTY RECEIVING (20)		MAJOR SURGERY SURGICAL BACKLOG (4 TABLES)
1._____	HOURS	1._____
2._____		2._____
3._____		3._____
4._____		4._____
5._____		
6._____		MINOR SURGERY
7._____		(2 TABLES)
8._____		
9._____		1._____
10._____		2._____
11._____		
12._____		
13._____		
14._____		
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18._____		
19._____		
20._____		

TAB F-20

PATIENT EVACUATION REQUEST

LEFT FACING PAGE

DISPATCH UPON RECEIPT TO

PATIENT NUMBER	EVAC PRIORITY	EVAC CLASS	ACCOMPANYING EQUIPMENT Y/N
1.			
2.			
3.			
4.			
5.			

PATIENT NUMBER	NAME	RANK/ RATE	SERVICE	SSN
1.				
2.				
3.				
4.				
5.				

TAB F-20

PATIENT EVACUATION REQUEST

RIGHT FACING PAGE

SPECIAL REQUIREMENTS	Y/N	BAGGAGE DESTINATION	Y/N	TOTAL WEIGHT

DX CODE	ACCOMPANYING EQUIPMENT	SPECIAL REQUIREMENTS	BAGGAGE WEIGHT	WEIGHT

FHF 6005

TAB F-25

MESSAGE FORMAT FOR ACTIVE DUTY PREADMITTED

UNCLASSIFIED

01 01 XXXXXXXZ XXX XX RR RR UUUU XXXXXXX

ADMIN

FROM FLEET HOSPITAL NO.
TO (MEMBERS CMD)
INFO COMNAVMEDCOM WASHINGTON DC
COMNAVMILPERSCOM WASHINGTON DC

UNCLAS //N06320//

SUBJ: (RANK, FIRST NAME, LAST NAME, SERVICE, SSN)

A. TRANSMAN CHAP 19

1. SNM HAS BEEN SCHEDULED FOR ELECTIVE ADMISSION TO THIS FLEET HOSPITAL ON (ADMISSION DATE) WITH A DIAGNOSIS OF ICD-9 CODE: (CODE).

2. SHOULD THE PROPOSED ADMISSION DATE CONFLICT WITH CMD OPERATIONAL COMMITMENTS, REQ NOTIFY THIS ACT BY MSG.

3. REQ TAD ORDS WITH DAILY NORM, DISCIPLINARY STATUS AND HEALTH.

(THIS MSG IS TO BE DONE ON ALL ACTIVE DUTY PERSONNEL WHO ARE

PREADMITTED, THIS INCLUDES ARMY. USE ONLY THE INFO'S THAT PERTAIN TO ANY ONE SERVICE.)

(DRAFTER NAME, RANK, SERVICE)

(DEPT HEAD OR OOD NAME, RANK, SERVICE & TITLE)

UNCLASSIFIED
XXXXXXZXXXXX
NOTE: ARMY MESSAGES WILL NOT HAVE ANY INFO'S

TAB F-25

MESSAGE FORMAT FOR ACTIVE DUTY NAVAL PERSONNEL

REPORT OF VERY SERIOUSLY ILL/SERIOUSLY ILL

UNCLASSIFIED
01 02 XXXXXXZ XXX XX PP PP UUUU XXXXXXX
FROM FLEET HOSPITAL NO.
TO COMNAVMILPERSCOM WASHINGTON DC
COMNAVBASE IN WHICH PNOK RESIDE
COMNAVBASE IN WHICH SNOK RESIDES
INFO COMNAVMEDCOM WASHINGTON DC
NAVY JAG ALEXANDRIA FA (IF RESULT OF ACCIDENT)
CNO WASHINGTON DC (IF CASUALTY IS INCIDENTAL TO NAVAL OPERATION)
UNCLAS //N01770//
SUBJ: PERSONNEL CASUALTY REPORT (VERY SERIOUSLY ILL/SERIOUSLY ILL)

A. NAVMILPERSMAN 4210100
(DRAFTER NAME, RANK, SERVICE)
(DEPT HEAD OR OOD NAME, RANK, SERVICE & TITLE)

UNCLASSIFIED
XXXXXXZXXXXX

1. FOLLOWING INFORMATION SUBMITTED IN ACCORDANCE WITH REF A
ALPHA: GRADE/RATE, FULL NAME, SSN, DESIGNATOR IF OFFICER
BRAVO: STATUS AND DUTY STATION (ACTIVE DUTY USS MYSHIP)

02 02 XXXXXXZ XXX XX PP PP UUUU XXXXXXX

ADMIN

CHARLIE: TYPE OF ILLNESS/INJURY OR DISEASE (NON-HOSTILE OR HOSTILE)
DELTA: DATE, TIME, AND PLACE OF OCCURRENCE
ECHO: CONDITION AND PROGNOSIS
FOXTROT: FULL NAME, ADDRESS AND RELATIONSHIP OF PNOK AND SNOK
GOLF: STATE WHETHER OR NOT PNOK AND SNOK HAVE BEEN OFFICIALLY NOTIFIED
HOTEL: POC PATIENT ADMINISTRATION (804) 398 5585 OR 5573

UNCLASSIFIED
XXXXXXZXXXXX

NOTE: DO CONFIRMATION MESSAGE ON ACTIVE DUTY PERSONNEL EVEN IF
NEXT OF KIN ARE LOCAL.

TAB F-25

MESSAGE FORMAT FOR NAVY ENLISTED WHEN ORDERS ARE WITH CHIT

UNCLASSIFIED
01 01 XXXXXXZ XXX XX RR RR UUUU XXXXXXX
ADMIN
FROM FLEET HOSPITAL NO.
TO (MEMBERS CMD)
UNCLAS //N06320//
SUBJ: (RANK, FULL NAME, USN SSN)
1. SNM WAS ADMITTED TO THIS NAVAL HOSPITAL AT (TIME) ON (DATE) WITH A DIAGNOSIS OF ICD-9 CODE: (CODE).
2. PLEASE ADVISE THIS CMD IF SNM IS IN DISCIPLINARY STATUS. (IF SNM IS E-7 OR ABOVE THIS LINE CAN BE OMITTED: ALSO NOTE: IF DISCIPLINARY STATUS STATED ON ORDERS THIS LINE CAN BE OMITTED.)
3. FWD DAILY NORM FOR PAY PURPOSES TO PSD. (IF STATED ON ORDS THIS LINE CAN BE OMITTED.)
4. THIS SMD UIC IS_____ .

(DRAFTER NAME, RANK, SERVICE)

(DEPT HEAD OR OOD NAME, RANK, SERVICE & TITLE)

UNCLASSIFIED
XXXXXXZXXXXX

TAB F-25

MESSAGE FORMAT FOR FLAG OR GENERAL OFFICER ADMISSION

UNCLASSIFIED
01 02 XXXXXXZ XXX XX PP PP UUUU XXXXXX
ADMIN
FROM FLEET HOSPITAL NO.
TO COMNAVMEDCOM WASHINGTON DC
INFO (OFFICERS CMD)
UNCLAS //N06320//
SUBJ: HOSPITALIZED (FLAG OR GENERAL) OFFICER REPORT
A. NAVMEDCOMINST 6320.30
1. FOR//474C//
2. (RANK, FULL NAME, SERVICE, SSN/DESIGNATOR NUMBER)
3. (DUTY ASSIGNMENT: ACTUAL POSITION AND LOCATION OF CMD)
(EXAMPLE: COMMANDING OFFICER, NAVSTA NORFOLK VA)
4. (ADMISSION DATE AND TIME, EXAMPLE, 01JUL86 AT 1200)
5. (PRESENT CONDITION, EXAMPLE: PRESENT CONDITION IS SATISFACTORY.)
6. DIAGNOSIS IS ICD-9CM CODE: (CODE NO)
7. EST PERIOD OF HOSPITALIZATION IS (GIVEN EXACT NUMBER OF DAYS)
(THIS REPORT MUST BE DONE ON ALL ACTIVE DUTY ADMIRALS AND GENERALS AND RETIRED MARINE CORPS GENERALS WHO ARE ADMITTED.)
(DRAFTERS NAME, RANK & SERVICE)

(DEPT HEAD OR OOD NAME, RANK, SERVICE & TITLE)

UNCLASSIFIED
XXXXXXZXXXXX
NOTE: SOME ADDRESSES ARE CHANGED DEPENDING ON BRANCH OF SERVICE
OF OFFICER. FOR COMPLETE GUIDANCE SEE BUMED INST 6320.25E
NAVSHOP INST 6320.14C)
UNCLASSIFIED
02 02 XXXXXXZ XXX XX PP PP UUUU XXXXXX
8. THIS CMD UIC IS_____.

UNCLASSIFIED
XXXXXXZXXXXX

TAB F-25

MESSAGE FORMAT FOR NAVAL RESERVIST ON ACTIVE DUTY ADMISSION

UNCLASSIFIED
01 01 XXXXXXZ XXX XX RR RR UUUU
XXXXXXX
ADMIN
FROM FLEET HOSPITAL NO.
TO NAVMARCORESCEN (ADD CITY AND STATE: LOOK IT UP)
INFO NAVRESPERSCEN NEW ORLEANS LA
UNCLAS //N06320//
SUBJ: (RANK, FULL NAME, USNR, SSN)
A. TRANSMAN 19.02
B. MILPERSMAN 5010260 (7)
C. COMNAVBASE NORFOLK VA INST 5830.1B (CIRCUMSTANCE INJURY ONLY)
D. CNAVRESINST 1770.20
E. JAGMAN 0805 (CIRCUMSTANCE INJURY ONLY)
1. (FROM HERE DOWN USE APPROPRIATE MESSAGE FORMAT FOR MEMBER ACCORDING TO HIS OR HER CIRCUMSTANCES) (USE FORMAT FOR REGULAR ACTIVE DUTY ADMISSION OR ACTIVE DUTY CIRCUMSTANCE ADMISSION)

(DRAFTER, NAME, RANK, & SERVICE)

(DEPT HEAD OR OOD NAME, RANK, SERVICE & TITLE)

UNCLASSIFIED
XXXXXXZXXXXX

TAB F-25

MESSAGE FORMAT FOR CANCELLATION OF MESSAGE

UNCLASSIFIED
01 01 XXXXXXZ XXX XX RR UUUU
XXXXXXX
ADMIN
FROM FLEET HOSPITAL NO.
TO (MEMBERS CMD)
INFO (ALL INFOS FROM ORIGINAL MESSAGE
SHOULD BE LISTED)
UNCLAS //N06320//
SUBJ: CANCELLATION OF MESSAGE
A. (RANK, NAME, SERVICE, & SSN OF MEMBER OF ORIGINAL MSG AND DATE TIME GROUP (EXAMPLE: YNSN BRYAN FLOWER USN 147 76 9574//101506ZJUN85))
1. IRT REF A, CANCEL REF A.

(DRAFTER NAME, RANK & SERVICE)

(DEPT HEAD OR OOD NAME, RANK, SERVICE & TITLE)
UNCLASSIFIED
XXXXXXZXXXXX

TAB F-25

MESSAGE FORMAT FOR AIR FORCE ENLISTED AND OFFICER ADMISSION

UNCLASSIFIED
01 01 XXXXXXZ XXX XX RR RR UUUU
XXXXXXX
ADMIN
FROM FLEET HOSPITAL NO.
TO (MEMBERS CMD)
INFO
UNCLAS //N06320//
SUBJ: (RANK, FULL NAME, USAF, SSN)
1. SNM (SNO FOR OFFICERS) WAS ADMITTED TO THIS NAVAL HOSPITAL AT (TIME) ON (DATE) WITH A DIAGNOSIS OF IDC-9 CODE: (CODE NO).
2. EST PERIOD OF HOSPITALIZATION IS (GIVE EXACT NUMBER OF DAYS).
3. THIS CMD UIC TO0_____.

(DRAFTER, NAME, RANK, & SERVICE)

(DEPT HEAD OR OOD NAME, RANK, SERVICE & TITLE)
UNCLASSIFIED
XXXXXXZXXXXX

TAB F-25

MESSAGE FORMAT FOR

ENLISTED AND OFFICER MARINE CORPS CIRCUMSTANCE ADMISSION

UNCLASSIFIED
01 01 XXXXXXZ XXX XX RR RR UUUU
XXXXXXX
ADMIN
FROM FLEET HOSPITAL NO.
TO (MEMBERS CMD)
UNCLAS //N06320//
SUBJ: (RANK, FULL NAME, USMC, SSN)
A. JAGMAN 0805 AND 0806
1. SNM (SNO FOR OFFICERS) WAS ADMITTED TO THIS NAVAL HOSPITAL AT (TIME) ON (DATE) WITH A DIAGNOSIS OF ICD-9 CODE: (CODE NO).
2. CIRCUMSTANCES: (TELL HOW, WHEN, WHERE ACCIDENT OR VIOLENCE HAPPENED) (EXAMPLE: SNM INVOLVED IN MVA IN LOCATION ON 01 JUL85/1200).
3. EST PERIOD OF HOSPITALIZATION IS (GIVEN EXACT NUMBER OF DAYS).
4. UPON COMPLETION OF REQUIRED ACTION OF REF A, FWD COPY OF COMPLETED LOD INVESTIGATION TO THIS CMD.
5. THIS CMD UIC IS_____.

(DRAFTER NAME, RANK, & SERVICE)

(DEPT HEAD OR OOD NAME, RANK, SERVICE & TITLE)
UNCLASSIFIED XXXXXXZXXXXX

TAB F-25

MESSAGE FORMAT FOR MARINE CORPS ENLISTED AND OFFICERS ADMISSION

UNCLASSIFIED
01 01 XXXXXXZ XXX XX RR RR UUUU
XXXXXXX
ADMIN
FROM FLEET HOSPITAL NO.
TO (MEMBERS CMD)
UNCLAS //N06320//
SUBJ: (RANK, FULL NAME, USMC, SSN)
1. SNM (SNO FOR OFFICERS) WAS ADMITTED TO THIS NAVAL HOSPITAL AT (TIME) ON (DATE) WITH A DIAGNOSIS OF ICD-9 CODE: (CODE NO).
2. EST PERIOD OF HOSPITALIZATION IS (GIVEN EXACT NUMBER OF DAYS).
3. THIS CMD UIC IS_____.

(DRAFTER NAME, RANK, & SERVICE)

(DEPT HEAD OR OOD NAME, RANK, SERVICE & TITLE)
UNCLASSIFIED
XXXXXXZXXXXX

TAB F-25

MESSAGE FORMAT FOR COAST GUARD CIRCUMSTANCE ADMISSION

UNCLASSIFIED
01 01 XXXXXXZ XXX XX RR RR UUUU
XXXXXXX
ADMIN
FROM FLEET HOSPITAL NO.
TO (MEMBERS CMD)
UNCLAS //N06320//
SUBJ: (RANK, NAME, USCG, SSN)
1. SNM (SNO FOR OFFICERS) WAS ADMITTED TO THIS NAVAL HOSPITAL AT (TIME) ON (DATE) WITH A DIAGNOSIS OF ICD-9 CODE: (CODE NO).
2. EST PERIOD OF HOSPITALIZATION IS (GIVE EXACT NUMBER OF DAYS).
3. CIRCUMSTANCES: (GIVE DATE, TIME, AND PLACE OF ACCIDENT OF VIOLENCE).
4. SNM'S (SNO'S FOR OFFICERS) ATTENDING DOCTOR IS (DOCTORS NAME) AND MAY BE REACHED AT .
5. THIS CMD UIC IS_____.

DRAFTER NAME, RANK & SERVICE)

(DEPT HEAD OR OOD NAME, RANK, SERVICE & TITLE)
UNCLASSIFIED
XXXXXXZXXXXX

NOTE: COAST GUARD CIRCUMSTANCES ADMISSION TO BE USED IN THE CASES INVOLVING ACCIDENTS, POISONINGS OR VIOLENCE.

TAB F-25

MESSAGE FORMAT FOR COAST GUARD OFFICER AND ENLISTED ADMISSION

UNCLASSIFIED
01 01 XXXXXXZ XXX XX RR UUUU
XXXXXXX
ADMIN
FROM FLEET HOSPITAL NO.
TO (MEMBERS CMD)
UNCLAS //N063420//
SUBJ: (RANK, FULL NAME, USCG, SSN)
1. SNM (SNO FOR OFFICERS) WAS ADMITTED TO THIS FLEET HOSPITAL AT (TIME) ON (DATE) WITH A DIAGNOSIS OF ICD-9 CODE: (CODE NO).
2. EST PERIOD OF HOSPITALIZATION IS UNDER (EXACT NUMBER OF DAYS).
3. SNM'S (SNO'S FOR OFFICERS) ATTENDING DOCTOR IS (DOCTORS NAME) AND MAY BE REACHED AT
.
4. THIS CMD UIC IS_____.

(DRAFTER NAME, RANK & SERVICE)

(DEPT HEAD OR OOD NAME, RANK, SERVICE & TITLE)
UNCLASSIFIED
XXXXXXZXXXXX

TAB F-25

MESSAGE FORMAT FOR

NAVY ENLISTED AND OFFICERS CIRCUMSTANCES ADMISSION

UNCLASSIFIED
01 02 XXXXXXZ XXX XX RR RR UUUU
XXXXXXX
ADMIN
FROM FLEET HOSPITAL NO.
TO (MEMBERS CMD)
INFO COMNAVMEDCOM WASHINGTON DC
COMNAVMILPERSCOM WASHINGTON DC
UNCLAS //N06320//
SUBJ: (RANK, FULL NAME, USN, SSN/DESIGNATOR-OFFICERS ONLY)
A. TRANSMAN 19 (ENLISTED ONLY) OR A. MILPERSMAN 1810520 (OFFICERS ONLY)
B. MILPERSMAN 5010260 (7) (ENLISTED ONLY)
C. JAGMAN 0805
D. COMNAVBASE NORFOLK VA INST 5830.1B
E. OPNAVINST 5102.1
1. SNM (SNO FOR OFFICERS) WAS ADMITTED TO THIS FLEET HOSPITAL AT (TIME) ON (DATE) WITH A DIAGNOSIS OF (SPELL OUT COMPLETE DIAGNOSIS).
2. TAD TRMNT ORDS ARE REQD FOR HOSP IAW REF A: IF TAD ORDS DID NOT ACCOMPANY SNM FOR HOSP, REQ PRPRE AND FWD ORDS TO PSD CODE EST PERIOD OF HOSP IS UNDER (SHIPS AND SQUADRONS - 30, SHORE STATIONS - 90, SUBS AND SEAL TEAMS - 90) DAYS.

(DRAFTER NAME, RANK, & SERVICE)

(DEPT HEAD OR OOD NAME, RANK, SERVICE & TITLE)
UNCLASSIFIED XXXXXXZXXXXX
UNCLASSIFIED
02 02 XXXXXXZ XXX XX RR RR UUUU
XXXXXXX
3. CIRCUMSTANCES: (TELL WHEN, HOW, WHERE AND WHAT TIME ACCIDENT OCCURED)
(EXAMPLE: SNM INVOLVED IN MVA IN LOCATION ON 01JUL86/1200).
4. PLEASE ADVISE THIS CMD IF SNM IS IN DISCIPLINARY STATUS. (DELETE THIS LINE IF E-7 OR ABOVE OR AN OFFICER).
5. UPON REQD ACTION OF REF C THRU #, FWD COPY OF NAVJAG 5800/15 OR LOD INVESTIGATION TO THIS CMD. THIS CMD UIC IS _____.
6. FWD DAILY NORM FOR PAY PURPOSES TO PSD _____.
(DELETE THIS LINE IF AN OFFICER ADMISSION.)

UNCLASSIFIED XXXXXXZXXXXX

TAB F-25

MESSAGE FORMAT FOR PATIENTS WITH IMMUNE DEFICIENCY - HIV

UNCLASSIFIED
01 01 XXXXXXZ XXX XX RR RR UUUU
XXXXXXX
ADMIN
FROM FLEET HOSPITAL NO.
TO (MEMBERS CMD)
INFO COMNAVMEDCOM WASHINGTON DC
COMNAVMILPERSCOM WASHINGTON DC
UNCLAS //N06320//
SUBJ: (RANK, NAME, USN, SSN/DESIGNATOR)
A. TRANSMAN 19
B. MILPERSMAN 5010260 (7)
1. SNM WAS ADMITTED TO THIS NAVAL HOSPITAL AT (TIME) ON (DATE).
2. TAD TRMNT ORDS ARE REQD FOR HOSP IAW REF A: IF TAD ORDS DID NOT ACCOMPANY SNM FOR HOSP, REQ PRPRE AND FWD ORDS TO PSD . EST PERIOD OF HOSPITALIZATION IS UNDER (SHIP - 30, SUBS AND SEAL TEAM - 90, SHORE STATIONS - 90 DAYS.)
3. PLEASE ADVISE THIS CMD IF SNM IS IN DISCIPLINARY STATUS. (FOR E-1 THRU E-6* IF NOTED ON TAD ORDS DELETE THIS LINE.)
4. FWD DAILY NORM FOR PAY PURPOSES TO PSD (IF NOTED ON ORDS DELETE
THIS LINE).
5. THIS CMD UIC IS_____.

(DRAFTERS NAME, RANK & SERVICE)

(DEPT HEAD OOD NAME, RANK, & SERVICE *TITLE)
UNCLASSIFIED
XXXXXXZXXXXX

TAB F-25

MESSAGE FORMAT FOR ACTIVE DUTY ENLISTED WITHOUT ADMISSION

UNCLASSIFIED
01 01 XXXXXXZ XXX XX RR RR UUUU
XXXXXXX
ADMIN
FROM FLEET HOSPITAL NO.
TO (MEMBERS CMD)
UNCLAS //N06320//
SUBJ: (RANK, NAME, USN, SSN)
A. TRANSMAN 19
B. MILPERSMAN (5010260 (7)
1. SNM WAS ADMITTED TO THIS FLEET HOSPITAL AT (TIME) ON (DATE) WITH A DIAGNOSIS OF ICD-9CM CODE: (CODE NO.)
2. TAD TRMNT ORDS ARE REQD FOR HOSP IAW REF A: IF TAD ORDS DID NOT ACCOMPANY SNM FOR HOSP, REQ PREPRE AND FWD ORDS TO (EXAMPLE PSD EST PERIOD OF HOSPITALIZATION IS UNDER (SHIP - 30, SUBS AND SEAL TEAMS - 90 DAYS, SHORE STATIONS - 90) DAYS.
3. PLEASE ADVISE THIS CMD IF SNM IS IN DISCIPLINARY STATUS (E-1 THRU E-6). 4. FWD DAILY NORM FOR PAY PURPOSES TO PSD LOCATION .
5. THIS CMD UIC IS_____.

(DRAFTERS NAME, RANK & SERVICE)

(DEPT HEAD OR OOD NAME, RANK, SERVICE & TITLE)
UNCLASSIFIED XXXXXXZXXXXX

TAB F-25

MESSAGE FORMAT FOR COMMANDING OFFICER ADMISSION REQUIREMENTS

UNCLASSIFIED
01 01 XXXXXXZ XXX XX RR RR UUUU
XXXXXXX
ADMIN
FROM FLEET HOSPITAL NO.
TO (MEMBERS CMD)
INFO COMNAVMEDCOM WASHINGTON DC
COMNAVMILPERSCOM WASHINGTON DC
UNCLAS //N06320//
SUBJ: (RANK, NAME, US, SSN/DESIGNATOR NO.)
A. MILPERSMAN 1810520
1. FOR//474C//
2. THE FOLLOWING INFO IS PROVIDED TO COMPLETE OFFICER HOSPITALIZATION RPT REQUIREMENTS IAW REF A.
A. SNO WAS ADMITTED TO THIS FLEET HOSPITAL AT (TIME) ON (DATE).
B. SNO WAS ADMITTED WITH A DIAGNOSIS OF ICD-9CM CODE: (CODE NO.).
C. SNO'S ESTIMATED PERIOD OF HOSPITALIZATION IS (GIVE EXACT NO. DAYS).
3. SNO'S ATTENDING DOCTOR IS DR. (DOCTORS NAME) AND MAY BE REACHED AT (GIVE DEPT OR CLINIC) EXTENSION (GIVE PHONE NUMBER). THIS CMD UIC IS _____ .

(DRAFTERS NAME, RANK, & SERVICE)

DEPT HEAD OR OOD NAME, RANK, SERVICE & TITLE)
UNCLASSIFIED XXXXXXZXXXXX

TAB F-27

2400 CENSUS REPORT

LEFT FACING PAGE

WARD NO._____

PATIENT CATEGORY	PATIENTS ON ROLLS			
	PREVIOUS DAY	GAINS	LOSSES	REM 2400
U.S. MARINE CORPS				
OFFICER				
ENLISTED				
U.S. NAVY				
OFFICER				
ENLISTED				
U.S. ARMY				
OFFICER				
ENLISTED				
U.S. AIR FORCE				
OFFICER				
ENLISTED				
FOREIGN NATIONALS				
ALLIED				
P.O.W.				
ALL OTHERS				

TOTAL

FHF 6006

TAB F-27

2400 CENSUS REPORT

RIGHT FACING PAGE

DATE: _____

YYMMDD

	ABSENT PATIENTS			
	AWOL	OTHER	TOTAL ABS.	BEDS OCCUP.
U.S. MARINE CORPS				
OFFICER				
ENLISTED				
U.S. NAVY				
OFFICER				
ENLISTED				
U.S. ARMY				
OFFICER				
ENLISTED				
U.S. AIR FORCE				
OFFICER				
ENLISTED				
FOREIGN NATIONALS				
ALLIED				
P.O.W.				
ALL OTHERS				
TOTAL				

FHF 6006